SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: Child Support Insurance Solution - Group Health	SERFF Tr Num: UHLC-126065089	State: ArkansasLH
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 41742
Sub-TOI: H16G.002B Large Group Only - POS	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Gary Officer	Disposition Date: 04/28/2009
	Date Submitted: 03/06/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: AR CSIS	Status of Filing in Domicile: Not Filed
Project Number: CSIS - AR 3-2009	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: The forms being submitted were developed with Arkansas-specific requirements and will not be filed or used in our domiciliary state of Connecticut
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Discretionary
Filing Status Changed: 04/28/2009	Explanation for Other Group Market Type:
	State Status Changed: 04/28/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Submission of group health insurance forms to provide a program of medical coverage for children in AR who are subjects of Medical Child Support Orders managed by the State of AR in accordance with Title IV-D of the Social Security Act.

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Company and Contact

Filing Contact Information

Gary Officer, Senior Contract Specialist
5901 Lincoln Dr
Edina, MN 55436

Gary_F_Officer@uhc.com
(952) 992-5515 [Phone]

Filing Company Information

United HealthCare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(215) 653-8046 ext. [Phone]

CoCode: 79413
Group Code: 707

Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health

State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	$0.00	03/06/2009	
United HealthCare Insurance Company	$100.00	03/11/2009	26316478

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/28/2009	04/28/2009
Approved-Closed	Rosalind Minor	03/25/2009	03/25/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	03/10/2009	03/10/2009	Gary Officer	03/11/2009	03/11/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Section 2 Exclusions	Form	Gary Officer	04/28/2009	04/28/2009
Section 4 Coverage Ends	Form	Gary Officer	03/24/2009	03/24/2009
Amendment to Group Policy	Form	Gary Officer	03/10/2009	03/13/2009
Intro to Your Certificate	Form	Gary Officer	03/10/2009	03/13/2009
Your	Form	Gary Officer	03/10/2009	03/13/2009

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Responsibilities

Table of Contents	Form	Gary Officer	03/10/2009	03/13/2009
Section1 Covered Health Services	Form	Gary Officer	03/10/2009	03/13/2009
Section 2 Exclusions	Form	Gary Officer	03/10/2009	03/13/2009
Section 3 Coverage Begins	Form	Gary Officer	03/10/2009	03/13/2009
Section 4 Coverage Ends	Form	Gary Officer	03/10/2009	03/13/2009
Section 8 General Legal Provisions	Form	Gary Officer	03/10/2009	03/13/2009
Section 9 Defined Terms	Form	Gary Officer	03/10/2009	03/13/2009

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Continuation of Coverage	Note To Filer	Rosalind Minor	03/23/2009	03/23/2009
AR CSIS - Draft of Revised Continuation of Coverage Provision	Note To Reviewer	Gary Officer	03/17/2009	03/17/2009
Filing Fee and Form POLAMD-CSIS-I.AR	Note To Filer	Rosalind Minor	03/10/2009	03/10/2009

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Disposition

Disposition Date: 04/28/2009
Implementation Date:
Status: Approved-Closed
Comment: This submission was re-opened in order for your to replace Form COL-CSISCP.EXC.I.07.AR. This new replacement form is being approved effective on this date.

The rest of the submission will maintain its approval date of 3/25/09.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Compliance Certification	Approved-Closed	Yes
Form	Group Policy	Approved-Closed	Yes
Form	Group Policy Cover Page	Approved-Closed	Yes
Form	Notice of Change to Exhibit 2	Approved-Closed	Yes
Form *(revised)*	Amendment to Group Policy	Approved-Closed	Yes
Form	Amendment to Group Policy	Replaced	Yes
Form	Notice of Additional Exhibit 2	Approved-Closed	Yes
Form	AR State Mandaated Offers Selection Form	Approved-Closed	Yes
Form	Insured Group Application	Approved-Closed	Yes
Form	Child Enrollment Application	Approved-Closed	Yes
Form	Certificate of Coverage	Approved-Closed	Yes
Form *(revised)*	Intro to Your Certificate	Approved-Closed	Yes
Form	Intro to Your Certificate	Replaced	Yes
Form *(revised)*	Your Responsibilities	Approved-Closed	Yes
Form	Your Responsibilities	Replaced	Yes
Form	Our Responsibilities	Approved-Closed	Yes
Form *(revised)*	Table of Contents	Approved-Closed	Yes
Form	Table of Contents	Replaced	Yes
Form *(revised)*	Section1 Covered Health Services	Approved-Closed	Yes
Form	Section1 Covered Health Services	Replaced	Yes
Form *(revised)*	Section 2 Exclusions	Approved-Closed	Yes
Form	Section 2 Exclusions	Replaced	Yes
Form	Section 2 Exclusions	Replaced	Yes
Form *(revised)*	Section 3 Coverage Begins	Approved-Closed	Yes
Form	Section 3 Coverage Begins	Replaced	Yes
Form *(revised)*	Section 4 Coverage Ends	Approved-Closed	Yes
Form	Section 4 Coverage Ends	Replaced	Yes

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Form	Section 4 Coverage Ends	Replaced	Yes
Form	Section 5 File a Claim	Approved-Closed	Yes
Form	Section 6 Complaints	Approved-Closed	Yes
Form	Section 7 COB	Approved-Closed	Yes
Form *(revised)*	Section 8 General Legal Provisions	Approved-Closed	Yes
Form	Section 8 General Legal Provisions	Replaced	Yes
Form *(revised)*	Section 9 Defined Terms	Approved-Closed	Yes
Form	Section 9 Defined Terms	Replaced	Yes
Form	Cover Page ChcPls	Approved-Closed	Yes
Form	Certificate of Coverage	Approved-Closed	Yes
Form	Intro to Your Certificate	Approved-Closed	Yes
Form	Your Responsibilities	Approved-Closed	Yes
Form	Our Responsibilities	Approved-Closed	Yes
Form	Table of Contents	Approved-Closed	Yes
Form	Section 1 Covered Health Services	Approved-Closed	Yes
Form	Section 2 Exclusions	Approved-Closed	Yes
Form	Section 3 Coverage Begins	Approved-Closed	Yes
Form	Section 4 Coverage Ends	Approved-Closed	Yes
Form	Section 5 Claims	Approved-Closed	Yes
Form	Section 6 Complaints	Approved-Closed	Yes
Form	Section 7 COB	Approved-Closed	Yes
Form	Section 8 General Legal Provisions	Approved-Closed	Yes
Form	Section 9 Defined Terms	Approved-Closed	Yes
Form	Cert Cover Page - Basic	Approved-Closed	Yes
Form	Sched. of Benefits ChcPls	Approved-Closed	Yes
Form	Sched. of Benefits Basics	Approved-Closed	Yes
Form	Outpatient Rx Rider	Approved-Closed	Yes
Form	Outpatient Rx Schedule of Benefits	Approved-Closed	Yes
Form	Vision Care Rider	Approved-Closed	Yes
Form	Dental Services Rider	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Disposition

Disposition Date: 03/25/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Compliance Certification	Approved-Closed	Yes
Form	Group Policy	Approved-Closed	Yes
Form	Group Policy Cover Page	Approved-Closed	Yes
Form	Notice of Change to Exhibit 2	Approved-Closed	Yes
Form *(revised)*	Amendment to Group Policy	Approved-Closed	Yes
Form	Amendment to Group Policy	Replaced	Yes
Form	Notice of Additional Exhibit 2	Approved-Closed	Yes
Form	AR State Mandaated Offers Selection Form	Approved-Closed	Yes
Form	Insured Group Application	Approved-Closed	Yes
Form	Child Enrollment Application	Approved-Closed	Yes
Form	Certificate of Coverage	Approved-Closed	Yes
Form *(revised)*	Intro to Your Certificate	Approved-Closed	Yes
Form	Intro to Your Certificate	Replaced	Yes
Form *(revised)*	Your Responsibilities	Approved-Closed	Yes
Form	Your Responsibilities	Replaced	Yes
Form	Our Responsibilities	Approved-Closed	Yes
Form *(revised)*	Table of Contents	Approved-Closed	Yes
Form	Table of Contents	Replaced	Yes
Form *(revised)*	Section1 Covered Health Services	Approved-Closed	Yes
Form	Section1 Covered Health Services	Replaced	Yes
Form *(revised)*	Section 2 Exclusions	Approved-Closed	Yes
Form	Section 2 Exclusions	Replaced	Yes
Form	Section 2 Exclusions	Replaced	Yes
Form *(revised)*	Section 3 Coverage Begins	Approved-Closed	Yes
Form	Section 3 Coverage Begins	Replaced	Yes
Form *(revised)*	Section 4 Coverage Ends	Approved-Closed	Yes
Form	Section 4 Coverage Ends	Replaced	Yes

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Form	Section 4 Coverage Ends	Replaced	Yes
Form	Section 5 File a Claim	Approved-Closed	Yes
Form	Section 6 Complaints	Approved-Closed	Yes
Form	Section 7 COB	Approved-Closed	Yes
Form *(revised)*	Section 8 General Legal Provisions	Approved-Closed	Yes
Form	Section 8 General Legal Provisions	Replaced	Yes
Form *(revised)*	Section 9 Defined Terms	Approved-Closed	Yes
Form	Section 9 Defined Terms	Replaced	Yes
Form	Cover Page ChcPls	Approved-Closed	Yes
Form	Certificate of Coverage	Approved-Closed	Yes
Form	Intro to Your Certificate	Approved-Closed	Yes
Form	Your Responsibilities	Approved-Closed	Yes
Form	Our Responsibilities	Approved-Closed	Yes
Form	Table of Contents	Approved-Closed	Yes
Form	Section 1 Covered Health Services	Approved-Closed	Yes
Form	Section 2 Exclusions	Approved-Closed	Yes
Form	Section 3 Coverage Begins	Approved-Closed	Yes
Form	Section 4 Coverage Ends	Approved-Closed	Yes
Form	Section 5 Claims	Approved-Closed	Yes
Form	Section 6 Complaints	Approved-Closed	Yes
Form	Section 7 COB	Approved-Closed	Yes
Form	Section 8 General Legal Provisions	Approved-Closed	Yes
Form	Section 9 Defined Terms	Approved-Closed	Yes
Form	Cert Cover Page - Basic	Approved-Closed	Yes
Form	Sched. of Benefits ChcPls	Approved-Closed	Yes
Form	Sched. of Benefits Basics	Approved-Closed	Yes
Form	Outpatient Rx Rider	Approved-Closed	Yes
Form	Outpatient Rx Schedule of Benefits	Approved-Closed	Yes
Form	Vision Care Rider	Approved-Closed	Yes
Form	Dental Services Rider	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/10/2009
Submitted Date	03/10/2009
Respond By Date	

Dear Gary Officer,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate of Coverage (Form)

Comment:

It is my understanding that you will be replacing this form.

Upon my review of this form and when you do submit a new form, your attention is called to the language for Continuation of Coverage.

Your Continuation of coverage should comply with ACA 23-86-114(f) (1)(2)(3)(4), which outlines when a Continuation of Coverage shall end. The language in your certificate does not comply.

Objection 2

- Section 4 Coverage Ends (Form)

Comment:

Your Continuation of Coverage language does not comply with our State Continuation Law, ACA 23-86-114(f)(1)(2)(3)(4).

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/11/2009
Submitted Date	03/11/2009

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Dear Rosalind Minor,

Comments:

Thank you for your very prompt response to our submission. In response to your objection letter, I have (1) attached the POLAMD-CSIS.I.AR form into the Form Schedule (this was previously and mistakenly left blank; (2) submitted an EFT filing fee payment, dated 3-11-09, transaction #26316478; and (3) replaced the incorrect Certificate of Coverage insert pages in the Form Schedule (9 forms-listed in objection 1 below).

Response 1

Comments: I did ot replace for COC-CSISCP.CER.I.07.AR because that form is correct; all other COC insert pages will go behind it. The forms that were replaced are: COC-CSISCP.INT.I.07.AR, COC-CSISCP.YRP.I.07.AR, COC-CSISCP.TOC.I.07.AR, COC-CSISCP.CHS.I.07.AR, COC-CSISCP.EXC.I.07.AR, COC-CSISCP-BGN.I.07.AR, COC-CSISCP.END.I.07.AR, COC-CSISCP.COC-CSISCP.LGL.I.07.AR, COC-CSISCP.DEF.I.07.AR

As we discussed in our telephone conversation this morning, we believe that our Continuation of Coverage language is appropriate, even though it doesn't match the language contained in your statutes, due to the nature of the product (medical coverage for children under an Arkansas support order) and the persons to be covered. We will need to study this further and get back to you before we can resolve this issue.

Related Objection 1

Applies To:

- Certificate of Coverage (Form)

Comment:

It is my understanding that you will be replacing this form.

Upon my review of this form and when you do submit a new form, your attention is called to the language for Continuation of Coverage.

Your Continuation of coverage should comply with ACA 23-86-114(f) (1)(2)(3)(4), which outlines when a Continuation of Coverage shall end. The language in your certificate does not comply.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

No Rate/Rule Schedule items changed.

Response 2

Comments: Note: This is the same answer as was given for Objection 1, because the topic is the same, as well as our response for right now. As we discussed in our telephone conversation this morning, we believe that our Continuation of Coverage language is appropriate, even though it doesn't match the language contained in your statutes, due to the nature of the product (medical coverage for children under an Arkansas support order) and the persons to be covered. We will need to study this further and get back to you before we can resolve this issue.

Related Objection 1

Applies To:

- Section 4 Coverage Ends (Form)

Comment:

Your Continuation of Coverage language does not comply with our State Continuation Law, ACA 23-86-114(f)(1)(2)(3)(4).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you again for your continuing cooperation and assistance. I will be sending you redline comparison documents, to assist you in identifying the changes to the replacement forms.

Sincerely,
Gary Officer

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Amendment Letter

Amendment Date:

Submitted Date: 04/28/2009

Comments:

Dear Ms Minor:

Attached is the revised Section 2 Exclusions and Limitations of the Arkansas CSIS (Child Support Insurance Solution) Certificate of Coverage. This is the document you reviewed and gave tentative approval to earlier today. No additional changes have been made. Thank you for your continuing assistance and cooperation.

Gary Officer

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC-CSISCP.EXC.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 2 Exclusions	Initial				43	COC-CSISCP.EXC.I.07.AR 4-24-09.pdf

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Amendment Letter

Amendment Date:

Submitted Date: 03/24/2009

Comments:

Dear Ms Minor:

I've replaced the previous form with a revised 3-24-09 version, per your request. I'm hoping you will now be able to give further consideration to the approval of this submission. Thank you again for your assistance and cooperation with this filing.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC-CSISCP.END.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 4 Coverage Ends	Initial				52	COC-CSISCP.END.I.07.AR - Rev 3-24-09.pdf

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Note To Filer

Created By:

Rosalind Minor on 03/23/2009 01:45 PM

Last Edited By:

Rosalind Minor

Submitted On:

03/25/2009 08:38 AM

Subject:

Continuation of Coverage

Comments:

Your draft for continuation of Coverage is acceptable. As soon as you incorporate it into the filing, the filing is ready to be approved.

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Note To Reviewer

Created By:

Gary Officer on 03/17/2009 07:10 AM

Last Edited By:

Rosalind Minor

Submitted On:

03/25/2009 08:38 AM

Subject:

AR CSIS - Draft of Revised Continuation of Coverage Provision

Comments:

Dear Ms. Minor:

Attached is a draft of a revised Continuation of Coverage provision. Please review this and let me know if it is acceptable. If so, we will incorporate the language into the appropriate insert page and submit it to you for final formal approval. Thank you for your help.

Gary Officer

Arkansas Child Support Insurance Solution - Continuation of Coverage

Continuation of Coverage is mandated in Arkansas for a period of 120 days.

[Continuation of Coverage]

[If your coverage ends under the Policy, you are entitled to continuation coverage (coverage that continues on in some form) in accordance with state law.]

[1]Enter the appropriate classification (State, Commonwealth, etc.)

[2]Enter the appropriate state name

[3]All references to the limiting age below are variable to allow adjustment by the State.

[Qualifying Events for Continuation Coverage under State Law]

[Coverage must have ended due to loss of eligibility as a Subscriber because either of the following occurs:

- You are no longer subject to a *Medical Child Support Order* managed by the [[1]State of [[2]Arkansas]] in accordance with *Title IV-D of the Social Security Act.*
- You have reached the limiting age of [[3]19].]

[Electing Continuation Coverage under State Law]

[You may elect continuation coverage under state law by continuing to pay timely Premiums after either of the qualifying events above occurs.]

[Terminating Events for Continuation Coverage under State Law]

[Continuation coverage under the Policy will end on the earliest of the following dates:

- 120 days from the date coverage would otherwise have terminated due to loss of eligibility.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under Medicare or any other group health plan.
- The date the Policy ends.]

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Amendment Letter

Amendment Date:

Submitted Date: 03/13/2009

Comments:

Dear Ms. Minor:

Apparently my revised forms were not attached to my response to your objection letter (probably my mistake) and that would seem to explain why you couldn't see the revised forms. Based on instructions from the SERFF Help Desk, once you receive this "amendment", you should be able to see the revised attachments. Please let me know if you still can not review the attachments.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
POLAMD-CSIS.I.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Amendment to Group Policy	Initial				46	AR 07I CSIS PolAmd.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC-CSISCP.INT.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Intro to Your Certificate	Initial				61	COC-CSISCP.INT.I.07.AR 3-10-09.pdf

Form Schedule Item Changes:

Form	Form	Form	Action	Form	Previous	Replaced	Readability	Attachments

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Number	Type	Name	Action	Action Other	Filing #	Form #	Score	
COC-CSISCP.YRP.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Your Responsibilities	Initial				56	COC-CSISCP.YRP.I.07.AR 3-10-09.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC-CSISCP.TOC.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Table of Contents	Initial				69	COC-CSISCP.TOC.I.07.AR 3-10-09.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC-CSISCP.CHS.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section1 Covered Health Services	Initial				45	COC-CSISCP.CHS.I.07.AR 3-10-09.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC-CSISCP.EXC.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 2 Exclusions	Initial				43	COC-CSISCP.EXC.I.07.AR 3-10-09.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action	Previous Filing #	Replaced Form #	Readability Score	Attachments

				Other				
COC-CSISCP.BGN.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 3 Coverage Begins	Initial				65	COC-CSISCP.BGN.I.07.AR 3-10-09.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC-CSISCP.END.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 4 Coverage Ends	Initial				52	COC-CSISCP.END.I.07.AR 3-10-09.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC-CSISCP.LGL.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 8 General Legal Provisions	Initial				48	COC-CSISCP.LGL.I.07.AR 3-10-09.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC-CSISCP.DEF.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 9 Defined Terms	Initial				48	COC-CSISCP.DEF.I.07.AR 3-10-09.pdf

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Note To Filer

Created By:

Rosalind Minor on 03/10/2009 02:03 PM

Last Edited By:

Rosalind Minor

Submitted On:

03/25/2009 08:38 AM

Subject:

Filing Fee and Form POLAMD-CSIS-I.AR

Comments:

As discussed in our telephone conversation, it is requested that you submit the $50.00 filing fee for this submission.

Also, Form POLAMD-CSIS.I.AR was not attached to the filing for review.

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Form Schedule

Lead Form Number: POL-CSIS.I.07.AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	POL-CSIS.I.07.AR	Policy/Contract/Fraternal Certificate	Group Policy	Initial		49	AR 07I CSIS Group Policy.pdf
Approved-Closed	PCOV-CSIS.I.07.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Group Policy Cover Page	Initial		69	AR 07I CSIS POL CVRPG.pdf
Approved-Closed	EXB2NTC-CSIS.I.07.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Notice of Change to Exhibit 2	Initial		49	AR 07I CSIS NTC POL EXH2.pdf
Approved-Closed	POLAMD-CSIS.I.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Amendment to Group Policy	Initial		46	AR 07I CSIS PolAmd.pdf
Approved-	EXB2NTCA	Policy/Cont	Notice of Additional	Initial		49	AR 07I CSIS

Closed	DD-CSIS.I.07.AR	ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Exhibit 2				NTC POL ADD EXH2.pdf
Approved-Closed	MAND-OFFERS.CSIS.I.08.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	AR State Mandaated Offers Selection Form	Initial		40	AR State Mandated Offers Selection Form.pdf
Approved-Closed	MCS.ER.08.AR 03/08	Application/Enrollment Form	Insured Group Application	Initial		40	CSIS Application for Group Policy.pdf
Approved-Closed	MCS.EE.08.AR 01/09	Application/Enrollment Form	Child Enrollment Application	Initial		46	M44220 AR medical child support - Final 1-16-09.pdf
Approved-Closed	COC-CSISCP.CER.I.07.AR	Certificate	Certificate of Coverage	Initial		71	COC-CSISCP.CER.I.07.AR.pdf
Approved-Closed	COC-CSISCP.INT.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Intro to Your Certificate	Initial		61	COC-CSISCP.INT.I.07.AR 3-10-09.pdf
Approved-Closed	COC-CSISCP.YRP.I.07.AR	Certificate Amendment, Insert	Your Responsibilities	Initial		56	COC-CSISCP.YRP.I.07.AR 3-10-

		Page, Endorsement or Rider					09.pdf
Approved-Closed	COC-CSISCP.ORP.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Our Responsibilities	Initial		51	COC-CSISCP.ORP.I.07.AR.pdf
Approved-Closed	COC-CSISCP.TOC.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Table of Contents	Initial		69	COC-CSISCP.TOC.I.07.AR 3-10-09.pdf
Approved-Closed	COC-CSISCP.CHS.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section1 Covered Health Services	Initial		45	COC-CSISCP.CHS.I.07.AR 3-10-09.pdf
Approved-Closed	COC-CSISCP.EXC.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 2 Exclusions	Initial		43	COC-CSISCP.EXC.I.07.AR 4-24-09.pdf
Approved-Closed	COC-CSISCP.BGN.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 3 Coverage Begins	Initial		65	COC-CSISCP.BGN.I.07.AR 3-10-09.pdf
Approved-Closed	COC-CSISCP.END.I.07.AR	Certificate Amendment, Insert Page, Endorsement	Section 4 Coverage Ends	Initial		52	COC-CSISCP.END.I.07.AR - Rev 3-24-09.pdf

		nt or Rider				
Approved-Closed	COC-CSISCP.CLM.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 5 File a Claim	Initial	65	COCCSISCP.CLM.I.07.AR.pdf
Approved-Closed	COC-CSISCP.CPL.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 6 Complaints	Initial	41	COC-CSISCP.CPL.I.07.AR.pdf
Approved-Closed	COC-CSISCP.COB.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 7 COB	Initial	46	COC-CSISCP.COB.I.07.AR.pdf
Approved-Closed	COC-CSISCP.LGL.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 8 General Legal Provisions	Initial	48	COC-CSISCP.LGL.I.07.AR 3-10-09.pdf
Approved-Closed	COC-CSISCP.DEF.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 9 Defined Terms	Initial	48	COC-CSISCP.DEF.I.07.AR 3-10-09.pdf
Approved-Closed	CCOV-CSISCP.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Cover Page ChcPls	Initial	69	AR 07I CSIS COC CVRPG - ChcPls.pdf
Approved-	COCCSISB	Certificate	Certificate of	Initial	71	COC-

Closed	.CER.I.07.AR	Coverage				CSISB.CER.I.07.AR.pdf
Approved-Closed	COC-CSISB.INT.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Intro to Your Certificate	Initial	61	COC-CSISB.INT.I.07.AR.pdf
Approved-Closed	COC-CSISB.YRP.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Your Responsibilities	Initial	56	COC-CSISB.YRP.I.07.AR.pdf
Approved-Closed	COC-CSISB.ORP.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Our Responsibilities	Initial	51	COC-CSISB.ORP.I.07.AR.pdf
Approved-Closed	COC-CSISB.TOC.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Table of Contents	Initial	69	COC-CSISB.TOC.I.07.AR.pdf
Approved-Closed	COC-CSISB.CHS.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 1 Covered Health Services	Initial	45	COC.CSISB.CHS.I.07.AR.pdf
Approved-Closed	COC-CSISB.EXC.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 2 Exclusions	Initial	43	COC-CSISB.EXC.I.07.AR.pdf

SERFF Tracking Number:	*UHLC-126065089*		*State:*	*Arkansas*			
Filing Company:	*United HealthCare Insurance Company*		*State Tracking Number:*	*41742*			
Company Tracking Number:							
TOI:	*H16G Group Health - Major Medical*		*Sub-TOI:*	*H16G.002B Large Group Only - POS*			
Product Name:	*Child Support Insurance Solution - Group Health*						
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*						

Approved-Closed	COC-CSISB.BGN.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 3 Coverage Begins	Initial		65	COC-CSISB.BGN.I.07.AR.pdf
Approved-Closed	COC-CSISB.END.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 4 Coverage Ends	Initial		52	COC-CSISB.END.I.07.AR.pdf
Approved-Closed	COC-CSISB.CLM.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 5 Claims	Initial		65	COC-CSISB.CLM.I.07.AR.pdf
Approved-Closed	COC-CSISB.CPL.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 6 Complaints	Initial		41	C0C-CSISB.CPL.I.07.AR.pdf
Approved-Closed	COC-CSISB.COB.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 7 COB	Initial		46	COC-CSISB.COB.I.07.AR.pdf
Approved-Closed	COC-CSISB.LGL.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Section 8 General Legal Provisions	Initial		48	COC-CSISB.LGL.I.07.AR.pdf
Approved-Closed	COC-CSISB.DEF	Certificate Amendment	Section 9 Defined Terms	Initial		48	COC-CSISB.DEF.I.

	.I.07.AR	t, Insert Page, Endorsement or Rider				07.AR.pdf
Approved-Closed	CCOV-CSISB.I.07.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Cert Cover Page - Basic	Initial	69	AR 07I CSIS COC CVRPG - UHB.pdf
Approved-Closed	SBN.CSISCP.I.07.AR	Schedule Pages	Sched. of Benefits ChcPls	Initial	50	AR 07I CSIS ChcPls SOB.pdf
Approved-Closed	SBN.CSISB.I.07.AR	Schedule Pages	Sched. of Benefits Basics	Initial	51	AR 07I CSIS UHB SOB.pdf
Approved-Closed	RDR.CSISRX.PLS.I.07.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Outpatient Rx Rider	Initial	56	AR 07I CSIS RxPls Rider.pdf
Approved-Closed	RDR.CSISRXSBN.PLS.I.07.AR	Schedule Pages	Outpatient Rx Schedule of Benefits	Initial	52	AR 07I CSIS RxPls SOB.pdf
Approved-Closed	VISION.RDR.CSIS.I.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Vision Care Rider	Initial	60	AR 07I CSIS Vision Rider.pdf
Approved-Closed	DENTAL.RDR.CSIS.I.	Policy/Contract/Fratern	Dental Services Rider	Initial	50	AR 07I CSIS Dental

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

AR	al Certificate: Amendment, Insert Page, Endorsement or Rider	Rider.pdf

Group Policy

[United HealthCare Insurance Company]

[450 Columbus Boulevard]

[Hartford, Connecticut 06115-0450]

[1-800-357-1371]

This Policy is entered into by and between [United HealthCare Insurance Company] and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to [United HealthCare Insurance Company].

Upon our receipt of the Enrolling Group's signed application, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan, except as provided in Exhibit 3.

This Policy will become effective on the date specified in Exhibit 1.

When this Policy is terminated, as described in Article 5, the Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

[United HealthCare Insurance Company]

[Signature of authorized company officer]

[Title of authorized company officer]

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

Coverage Classification - the category of coverage described in Exhibit(s) 2 for rating purposes.

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Article 2: Benefits

Subscribers are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

Article 3: Premium Rates

3.1 Premiums

Monthly Premiums payable by or on behalf of Subscribers are specified in the Schedule of Premium Rates in Exhibit(s) 2 of this Policy or in any attached Notice of Change.

We reserve the right to change the Schedule of Premium Rates as described in Exhibit 1 of this Policy. We also reserve the right to change the Schedule of Premium Rates at any time if the Schedule of Premium Rates was based upon a Material Misrepresentation that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We reserve the right to change the Schedule of Premium Rates for this reason retroactive to the effective date of the Schedule of Premium Rates that was based on the Material Misrepresentation.

3.2 Adjustments

[1] *Enter the appropriate number of days.*

We may make retroactive adjustments for any additions or terminations of Subscribers that are not reflected in our records. We will not grant retroactive credit for any change occurring more than [[1]30 - 90] days prior to the date we received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing within [[1]30 - 90] days of the effective date of enrollments, terminations, or other changes.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will automatically be added to the Premium. In addition, any change in law or regulation that significantly affects our cost of operation will result in an increase in Premium in an amount we determine.

3.3 Payment of Premiums

Premiums are payable to us in advance by or on behalf of Subscribers as described under "Payment of the Premium" in Exhibit 1. Premiums are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.

A service charge will be assessed for any non-sufficient-fund check received in payment of Premium. All Premium payments must be accompanied by supporting documentation that states the name of the Subscriber for whom payment is being made.

We are entitled to reimbursement of attorney's fees and any other costs related to collecting delinquent Premiums.

3.4 Assignment of Rights

The Enrolling Group hereby assigns any and all collection rights to us to pursue delinquent Premiums due and owing under the Policy. Exercising these rights is at our discretion.

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for the class are stated in the corresponding Exhibit(s) 2. The eligibility conditions stated in Exhibit(s) 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons may enroll for coverage under this Policy during the Initial Enrollment Period. We and the Enrolling Group determine the Initial Enrollment Period.

4.3 Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons is stated in Exhibit(s) 2.

4.4 Requirements for Enrolling Group's Enrollment Process

The Enrolling Group shall adopt a formal enrollment process whereby uninsured children that are required to have medical insurance pursuant to a *Medical Child Support Order* (“MCSO”) are automatically enrolled in a medical insurance plan if such children remain uninsured for a certain number of days after the MSCO is entered.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

A. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

B. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group provided us with false information material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

- The effective date of this Policy.
- The date we received the false information, if later.

C. On the date we specify, after at least [90 - 365] days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.

D. On the date we specify, after at least [180 - 365] days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any health benefit plan within the applicable market.

E. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group failed to meet the requirements outlined in Article 4.4 above.

5.2 Conditions for Termination of Subscriber's Coverage

Coverage terminates for Subscribers on the earliest of the dates specified below:

- **The Entire Policy Ends**

  The Subscriber's coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying the Subscriber that coverage has ended.

- **Failure to Pay Premium**

[1]Include when the one or two months' advance Premium options applies.

[2]Include when Standard payment option applies.

[3]Include only when two months' Premium payment option applies.

  The Subscriber's coverage ends on the last day [[1]of the last calendar month for which Premium was paid in full] [[2]of the grace period, if the grace period expires and Premium remains unpaid]. [[3]Premium is considered to be paid in full when the initial two months' Premium has been remitted and payment is received every month thereafter. If a monthly Premium payment is missed, coverage will terminate on the last day of the following calendar month. For example: A Subscriber's coverage begins May 1 (by having paid two months' Premium by April 30). If the May Premium payment is not submitted, the Subscriber's coverage will terminate on June 30.]

- **The Subscriber Is No Longer Eligible**

  The Subscriber's coverage ends on the last day of the calendar month in which he or she is no longer eligible to be a Subscriber. Please refer to *Section 9: Defined Terms* for complete definitions of the terms Eligible Person and Subscriber.

- **We Receive Notice to End Coverage**

  The Subscriber's coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end coverage.

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or the Subscriber knowingly gave us false material information. Examples include false information relating to eligibility.

  During the first two years the Policy is in effect, we have the right to demand that the Subscriber pay back all Benefits we paid to the Subscriber, or paid in the Subscriber's name, during the time the Subscriber was incorrectly covered under the Policy. After the first two years, we can only demand that the Subscriber pay back these Benefits if the written application contained a fraudulent misstatement.

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  The Subscriber committed acts of physical or verbal abuse that pose a threat to our staff.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

6.2 Dispute Resolution

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within thirty (30) days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the Federal Arbitration Act applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to arbitration pursuant to the rules of the American Arbitration Association.

Arbitration will take place in [Hartford County, Connecticut].

The matter must be submitted to arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of the Policy, and will be bound by controlling law.

6.3 Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of two years.

6.4 Amendments and Alterations

Amendments to this Policy are effective 31 days after we send written notice to the Enrolling Group. Riders are effective on the date we specify. Other than changes to Exhibit(s) 2 stated in a Notice of Change to Exhibit(s) 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

6.5 Relationship Between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Subscriber is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Subscriber.

6.6 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Subscriber authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and

records or copies of records relating to the health care services provided to the Subscriber. We have the right to request this information at any reasonable time.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.7 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee as specified in Exhibit 3 Administrative Services. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then-current charges for such services or reports.

6.8 Examination of Subscribers

In the event of a question or dispute concerning Benefits for Covered Health Services, we may reasonably require that a Network Physician, acceptable to us, examine the Subscriber at our expense.

6.9 Clerical Error

[1]*The number here should match the adjustment period number used in Article 3.2.*

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Subscriber beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage for more than [[1]30 - 90] days of coverage prior to the date we received notification of the clerical error.

6.10 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

6.11 Notice

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

6.12 Certification of Coverage Forms

As required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), we will produce certification of coverage forms for Subscribers who lose coverage under this Policy. Except as otherwise provided herein, the Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on such eligibility and termination data which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

6.13 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to each covered Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the

Benefits and other provisions of this Policy. In addition, access to the *Certificate of Coverage(s)* and *Schedule(s) of Benefits* may be available online at [www.myuhc.com].

6.14 System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

Exhibit 1

1. **Parties.** The parties to this Policy are [United HealthCare Insurance Company] and _____, the Enrolling Group.

[1]Insert month, day and year.

2. **Effective Date.** The effective date of coverage under this Policy is 12:01 a.m. on [[1]_____, ____] in the time zone of the Enrolling Group's location. The effective date of administrative services under this Policy is 12:01 a.m. on [[1]_____, ____] in the time zone of the Enrolling Group's location.

3. **Place of Issuance.** We are delivering this Policy in the State of Arkansas. The laws of the State of Arkansas are the laws that govern this Policy.

[1]Include when premiums are specified in the Cost Summary. Cost Summary is variable to allow for name change.

[2]Select the appropriate length of time for prior written notice, based on group requirement.

4. **Premiums.** We reserve the right to change the Schedule of Premium Rates [[1]or [Cost Summary]] specified in Exhibit(s) 2, after a [[2]31 - 120]-day prior written notice with respect to coverage effective dates or coverage months not shown in Exhibit(s) 2, Schedule of Premium Rates.

5. **Computation of Premiums.** A full month's Premium will be charged for any Subscriber who is covered under this Policy. Coverage is effective on the first of the month and ends at the end of the month. Premiums will not be prorated based upon the Subscriber's effective date or termination date of coverage. The only exception to this requirement is that a pro rata Premium, based on the number of days a Subscriber is actually covered under this Policy, will be charged for a Subscriber whose coverage is terminated due to death.

[1]Include only when two months' Premium payment is required. Delete if only a single month's Premium is required.

6. **Payment of the Premium.** The Premium is payable to us in advance on a monthly basis by or on behalf of Subscribers. [[1]200% of the monthly Premium is required payment for each Subscriber in order for coverage to begin, with monthly Premium payments required for each Subscriber thereafter.]

7. **Notice.** Any notice sent to us under this Policy must be addressed to:

_____

(Name of Issuing Entity)

_____

(Address)

_____

(City, State, Zip)

Any notice sent to the Enrolling Group under this Policy must be addressed to:

_____

(Enrolling Group)

_____

(Address)

_____

(City, State, Zip)

[8]. [____ Enrolling Group Number]

[1]Insert the applicable state name when policy is issued to support a consortium policy holder arrangement. Do not include when policy is issued to support a single state policyholder.

Exhibit 2 [[1]for the State of Arkansas]

1. **Class Description.**

   Children who meet each of the following conditions:

Limiting age is variable to allow adjustment by the State.

- At least seven months old but less than [19] years old.
- Subject of a *Medical Child Support Order* managed by the [State of [Arkansas]] in accordance with *Title IV-D* of the *Social Security Act*.

Insert eligibility conditions below. If there are no specific eligibility conditions that apply, the default will show "none."

2. **Eligibility.** The eligibility rules are established by us and the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage*:

   Other:

   [_____]

[1]Enter effective date of coverage.

3. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of the Policy is [1][_____].

[1]Include only when two months' Premium payment is required. [2]Include if only a single month's Premium is required.

   For an Eligible Person who becomes eligible after the effective date of the Policy, his or her effective date of coverage is the first day of the month following the date on which we have received [[1]at least 200% of monthly Premiums] [[2]Premium] on the Eligible Person's behalf.

[1]Insert applicable table when rates are shown in Exhibit 2. Duplicate as needed to allow inclusion of multiple rate statements by benefit plan design.

[2]Insert effective date.

[3]Insert when rates are issued via the Cost Summary. Cost Summary is variable to allow for name change.

4. **Schedule of Premium Rates.**

   [[1]The Schedule of Premium Rates payable by or on behalf of the class of Subscribers as of [[2]_____] is shown below:

[[1] Plan ___

Coverage Classification	Coverage Effective Date	Coverage Months	Monthly Premium
Subscriber Only	01/01/[2008]	12/31/[2008]	[$_____]
Subscriber Only	02/01/[2008]	01/31/[2009]	[$_____]
Subscriber Only	03/01/[2008]	02/28/[2009]	[$_____]
Subscriber Only	04/01/[2008]	03/31/[2009]	[$_____]
Subscriber Only	05/01/[2008]	04/30/[2009]	[$_____]

Subscriber Only	06/01/[2008]	05/31/[2009]	[$_____]
Subscriber Only	07/01/[2008]	06/30/[2009]	[$_____]
Subscriber Only	08/01/[2008]	07/31/[2009]	[$_____]
Subscriber Only	09/01/[2008]	08/31/[2009]	[$_____]
Subscriber Only	10/01/[2008]	09/30/[2009]	[$_____]
Subscriber Only	11/01/[2008]	10/31/[2009]	[$_____]
Subscriber Only	12/01/[2008]	11/30/[2009]	[$_____]
Subscriber Only	01/01/[2009]	12/31/[2009]	[$_____]

]

[[1] Plan ___

Coverage Classification	Coverage Effective Date	Coverage Months	Monthly Premium
Subscriber Only	[01/01/[2008] - 03/31/[2008]]	[01/01/[2008] - 03/31/[2009]]	[$_____]
Subscriber Only	[04/01/[2008] - 06/30/[2008]]	[04/01/[2008] - 06/30/[2009]]	[$_____]
Subscriber Only	[07/01/[2008] - 09/30/[2008]]	[07/01/[2008] - 09/30/[2009]]	[$_____]
Subscriber Only	[10/01/[2008] - 12/31/[2008]]	[10/01/[2008] - 12/31/[2009]]	[$_____]

]

[[1] Plan ___

Coverage Classification	[Coverage Effective Date]	[Coverage Months]	Monthly Premium
Subscriber Only	[_____]	[_____]	[$_____]
Subscriber Only	[_____]	[_____]	[$_____]
Subscriber Only	[_____]	[_____]	[$_____]
Subscriber Only	[_____]	[_____]	[$_____]

]

[Changes to this Schedule of Premium Rates and/or subsequent Schedules of Premium Rates will be attached to this Policy by means of a Notice of Change to Exhibit 2.]

[[3]Monthly Premiums payable by or on behalf of Subscribers are specified in the [Cost Summary].]

Exhibit 3 - Administrative Services

This Administrative Services Exhibit shall be effective on [enter effective date].

We, either directly or through our vendor, shall provide the following additional administrative services related to the Policy:

1. Identify Eligible Persons using resources made available to us by the Enrolling Group and other available data sources.
2. Assist Eligible Persons to enroll in the Policy by collecting enrollment paperwork and advance Premium payments and completing automatic enrollment in the Policy, as agreed upon by the Enrolling Group
3. Bill, collect and reconcile Subscribers due Premiums.
4. Identify delinquent premium payments by Subscribers and pursue compliance by responsible party through outreach and Enrolling Group support.
5. Provide call center support for Eligible Persons regarding plan enrollment and premium/cash payment.
6. Provide consultative support regarding implementation to assist the Enrolling Group to support medical child support activities, including, but not limited to, conducting a review of present medical child support processes to identify potential *Medical Child Support Orders*, providing advice around work flow and form modifications to support creation of *Medical Child Support Orders*, ongoing technical assistance and consultation to the Enrolling Group regarding the medical child support program, and follow up consultation to encourage compliance with *Medical Child Support Orders*.
7. Educating key stakeholders in the Enrolling Group's medical child support community about the Policy and related medical child support issues. Key stakeholders include, but are not limited to, select personnel in the Enrolling Group, the judicial community dealing with *Medical Child Support Orders*, and the legal community dealing with *Medical Child Support Orders*.
8. Produce periodic reports on medical child support enrollment to support Enrolling Group requirements, as mutually agreed upon by us and the Enrolling Group.

[Exhibit 4 - Miscellaneous Provisions]

Use this page to create a cover if the state requires that we have a "Cover Page" to include required information.

[Child Support Insurance Solution] [-] [HealthBright^{SM} Choice Plus] [HealthBright^{SM} Basics]

[United HealthCare Insurance Company]

[450 Columbus Boulevard]

[Hartford, Connecticut 06115-0450]

[1-800-357-1371]

ARKANSAS MANDATE DISCLOSURE NOTICE

Arkansas Statutes 23-79-801, et seq. authorizes us to offer a health insurance policy or plan which does not include all of the state mandated health benefits normally required in insurance policies or contracts in Arkansas. Examples of state mandated health insurance benefits which do not have to be included are dental anesthesia and hospitalization, in-vitro fertilization, and temporomandibular joint disorders (TMJ). The Arkansas mandated health insurance benefits not included in this health insurance policy are listed below.

Please consult your health insurance agent for information about any state health benefit that is not included in this health insurance policy. This health insurance policy may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefit coverages than those normally imposed on health insurance policies or plans in Arkansas.

If you have any questions or concerns related to the nature of any state mandated health benefit not included in this health insurance policy, please consult with:

- Your health insurance agent or
- The Arkansas Insurance Department Consumer Affairs or Legal Division.

The Arkansas mandated health benefits not included in this health insurance policy are:

- [Alcohol and Drug Dependency Treatment]
- [Ambulatory Surgical Center Coverage]
- [Children's Preventive Health Care]
- [Colorectal Cancer Screening]
- [Coverage for outpatient prescription drug or devices for use as a contraceptive]
- [Dental Point of Service Coverage]
- [Dental Anesthesia and Hospitalization]
- [Diabetes Self-Management and Training]
- [Hospice Care]
- [In-Vitro Fertilization]
- [Mammography Screening]

- [Medical Foods]
- [Mental Health Parity]
- [Musculoskeletal Disorders]
- [Off-Label Use of Drugs]
- [Speech or Hearing Impairment]
- [Temporomandibular Joint Disorders]

[1]Insert the applicable state name when policy is issued to support a consortium policy holder arrangement. Do not include when policy is issued to support a single state policyholder.

Notice of Change to Exhibit 2 [[1]for the State of Arkansas]

Effective [_____], the following provision(s) included in Exhibit 2 of this Policy [[1]for the State of [Arkansas]] are replaced by the provision(s) shown below.

Enter new or revised information below as applicable.

[1]Enter when class description is entered directly in Exhibit 2.

[1.] **[Class Description.]**

[1][Children who meet each of the following conditions:

Limiting age is variable to allow adjustment by the State.

- At least seven months old but less than [19] years old.
- Subject of a *Medical Child Support Order* managed by the [State of [Arkansas]] in accordance with *Title IV-D* of the *Social Security Act.*]

Insert eligibility conditions below. If there are no specific eligibility conditions that apply, the default will show "none."

[2.] **[Eligibility.** The eligibility rules are established by us and the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage:*

Other:

[_____]]

[1]Enter effective date of coverage.

[3.] **[Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of the Policy is [1][_____].

[1]Include only when two months' Premium payment is required. [2]Include if only a single month's Premium is required.

For an Eligible Person who becomes eligible after the effective date of the Policy, his or her effective date of coverage is the first day of the month following the date on which we have received [[1]at least 200% of monthly Premiums] [[2]Premium] on the Eligible Person's behalf.]

[1]Insert applicable table when rates are shown in Exhibit 2. Duplicate as needed to allow inclusion of multiple rate statements by benefit plan design.

[2]Insert effective date.

[3]Insert when rates are issued via the Cost Summary. Cost Summary is variable to allow for name change.

[4.] **[Schedule of Premium Rates.]**

[[1]The Schedule of Premium Rates payable by or on behalf of the class of Subscribers as of [[2]_____] is shown below:

[[1] Plan ___

Coverage Classification	Coverage Effective Date	Coverage Months	Monthly Premium
Subscriber Only	01/01/[2008]	12/31/[2008]	[$_____]

Subscriber Only	02/01/[2008]	01/31/[2009]	[$_____]
Subscriber Only	03/01/[2008]	02/28/[2009]	[$_____]
Subscriber Only	04/01/[2008]	03/31/[2009]	[$_____]
Subscriber Only	05/01/[2008]	04/30/[2009]	[$_____]
Subscriber Only	06/01/[2008]	05/31/[2009]	[$_____]
Subscriber Only	07/01/[2008]	06/30/[2009]	[$_____]
Subscriber Only	08/01/[2008]	07/31/[2009]	[$_____]
Subscriber Only	09/01/[2008]	08/31/[2009]	[$_____]
Subscriber Only	10/01/[2008]	09/30/[2009]	[$_____]
Subscriber Only	11/01/[2008]	10/31/[2009]	[$_____]
Subscriber Only	12/01/[2008]	11/30/[2009]	[$_____]
Subscriber Only	01/01/[2009]	12/31/[2009]	[$_____]

]

[[1] Plan ___

Coverage Classification	Coverage Effective Date	Coverage Months	Monthly Premium
Subscriber Only	[01/01/[2008] - 03/31/[2008]]	[01/01/[2008] - 03/31/[2009]]	[$_____]
Subscriber Only	[04/01/[2008] - 06/30/[2008]]	[04/01/[2008] - 06/30/[2009]]	[$_____]
Subscriber Only	[07/01/[2008] - 09/30/[2008]]	[07/01/[2008] - 09/30/[2009]]	[$_____]
Subscriber Only	[10/01/[2008] - 12/31/[2008]]	[10/01/[2008] - 12/31/[2009]]	[$_____]

]

[[1] Plan ___

Coverage Classification	[Coverage Effective Date]	[Coverage Months]	Monthly Premium
Subscriber Only	[_____]	[_____]	[$_____]
Subscriber Only	[_____]	[_____]	[$_____]
Subscriber Only	[_____]	[_____]	[$_____]
Subscriber Only	[_____]	[_____]	[$_____]

]

[Changes to this Schedule of Premium Rates and/or subsequent Schedules of Premium Rates will be attached to this Policy by means of a Notice of Change to Exhibit 2.]

[[3]Monthly Premiums payable by or on behalf of Subscribers are specified in the [Cost Summary].]

Amendment to Group Policy Among

[United HealthCare Insurance Company]

Enter name of AR Consortium as listed in the Policy:

[_____]

Enter name of new state entity.

and [_____]

Enter effective date.

This Amendment modifies the Group Policy (the "Policy") entered into by and between [United HealthCare Insurance Company] and the Enrolling Group, effective [_____].

[1]Enter new state entity.

[2]Enter new state entity nickname.

Whereas, [[1]_____] ("[[2]_____]") wishes to piggyback on the Enrolling Group's contract, join the purchasing consortium led by the Enrolling Group and thereby be added to the terms of the Policy;

Now, therefore, the Policy is hereby amended as follows:

[1]Enter new state entity nickname.

1. The definition of the term "Enrolling Group" as such is used within the Policy shall be amended to also include [[1]_____]. [[1]_____] agrees to accept all of the terms and conditions of the Policy. A copy of such Policy is attached hereto as Attachment 1.
2. [[1]_____] agrees to accept all of the terms and conditions outlined in the Insured Group Application as executed by the Enrolling Group, a copy of such Insured Group Application is attached hereto as Attachment 2.
3. Termination Rights. In addition to the rights outlined in the Policy, this Amendment and all Benefits for Covered Health Services under this Amendment will automatically terminate on the earliest of the dates specified below:
    a. On the date specified by [[1]_____], after at least 31 days prior written notice to us that this Amendment is to be terminated;
    b. On the date we specify, after at least 31 days prior written notice to the [[1]_____], that this Amendment is to be terminated because [[1]_____] provided us with false information material to the execution of this Amendment or to the provision of coverage under this Amendment. In this case, we have the right to rescind this Amendment back to either:
        i. The effective date of this Amendment; or,
        ii. The date we received the false information, if later;
    c. On the date we specify, after at least [90] days prior written notice to [[1]_____], that this Amendment is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market;
    d. On the date we specify, after at least [180] days prior written notice to the applicable state authority and to [[1]_____], that this Amendment is to be terminated because we will no longer issue any employer health benefit plan within the applicable market; or,

e. On the date we specify, after at least 31 days prior written notice to the [1_____], that this Amendment is to be terminated because [1_____] failed to meet the requirements outlined in Article 4.4 of the Policy.

[1]*Enter name of AR Consortium as listed in the Policy.*

[1_____]

[By: _____]

Name: _____

Title: _____

Date: _____

[United HealthCare Insurance Company]

[By: _____]

Name: _____

Title: _____

Date: _____

[1]*Enter new state entity*

[_____]

[By: _____]

Name: _____

Title: _____

Date: _____

[1]Insert the applicable state name when policy is issued to support a consortium policy holder arrangement.

Notice of Additional Exhibit 2 for the [[1]State of Arkansas]

Effective [_____], this additional Exhibit 2 for the [[1]State of [Arkansas]] is included in the Policy.

1. **Class Description.**

   Children who meet each of the following conditions:

Limiting age is variable to allow adjustment by the State.

- At least seven months old but less than [19] years old.
- Subject of a *Medical Child Support Order* managed by the [State of [Arkansas]] in accordance with *Title IV-D* of the *Social Security Act*.

Insert eligibility conditions below. If there are no specific eligibility conditions that apply, the default will show "none."

2. **Eligibility.** The eligibility rules are established by us and the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage:*

   [Other:]

   [_____]]

[1]Enter effective date of coverage.

3. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the date the [State of [Arkansas]] is added to the terms of the Policy is [1][_____].

[1]Include only when two months' Premium payment is required. [2]Include if only a single month's Premium is required.

   For an Eligible Person who becomes eligible after the date the [State of [Arkansas]] is added to the terms of the Policy, his or her effective date of coverage is the first day of the month following the date on which we have received [[1]at least 200% of monthly Premiums] [[2]Premium] on the Eligible Person's behalf.

[1]Insert applicable table when rates are shown in Exhibit 2. Duplicate as needed to allow inclusion of multiple rate statements by benefit plan design.

[2]Insert effective date.

[3]Insert when rates are issued via the Cost Summary. Cost Summary is variable to allow for name change.

4. **Schedule of Premium Rates.**

   [[1]The Schedule of Premium Rates payable by or on behalf of the class of Subscribers as of [[2]_____] is shown below:

[[1] Plan ___

Coverage Classification	Coverage Effective Date	Coverage Months	Monthly Premium
Subscriber Only	01/01/[2008]	12/31/[2008]	[$_____]
Subscriber Only	02/01/[2008]	01/31/[2009]	[$_____]

Subscriber Only	03/01/[2008]	02/28/[2009]	[$_____]
Subscriber Only	04/01/[2008]	03/31/[2009]	[$_____]
Subscriber Only	05/01/[2008]	04/30/[2009]	[$_____]
Subscriber Only	06/01/[2008]	05/31/[2009]	[$_____]
Subscriber Only	07/01/[2008]	06/30/[2009]	[$_____]
Subscriber Only	08/01/[2008]	07/31/[2009]	[$_____]
Subscriber Only	09/01/[2008]	08/31/[2009]	[$_____]
Subscriber Only	10/01/[2008]	09/30/[2009]	[$_____]
Subscriber Only	11/01/[2008]	10/31/[2009]	[$_____]
Subscriber Only	12/01/[2008]	11/30/[2009]	[$_____]
Subscriber Only	01/01/[2009]	12/31/[2009]	[$_____]

]

[[1] Plan ___

Coverage Classification	Coverage Effective Date	Coverage Months	Monthly Premium
Subscriber Only	[01/01/[2008] - 03/31/[2008]]	[01/01/[2008] - 03/31/[2009]]	[$_____]
Subscriber Only	[04/01/[2008] - 06/30/[2008]]	[04/01/[2008] - 06/30/[2009]]	[$_____]
Subscriber Only	[07/01/[2008] - 09/30/[2008]]	[07/01/[2008] - 09/30/[2009]]	[$_____]
Subscriber Only	[10/01/[2008] - 12/31/[2008]]	[10/01/[2008] - 12/31/[2009]]	[$_____]

]

[[1] Plan ___

Coverage Classification	[Coverage Effective Date]	[Coverage Months]	Monthly Premium
Subscriber Only	[_____]	[_____]	[$_____]
Subscriber Only	[_____]	[_____]	[$_____]
Subscriber Only	[_____]	[_____]	[$_____]
Subscriber Only	[_____]	[_____]	[$_____]

]

[Changes to this Schedule of Premium Rates and/or subsequent Schedules of Premium Rates will be attached to this Policy by means of a Notice of Change to Exhibit 2.]

[[3]Monthly Premiums payable by or on behalf of Subscribers are specified in the [Cost Summary].]

ARKANSAS STATE MANDATED OFFERS SELECTION FORM

Arkansas statutes require the optional coverages listed below to be offered to each group. Your group can separately accept or reject each "mandated offer". Your Broker or agent can provide you with additional information, including any additional premium amount(s) required for the mandated offers. Please note that not all mandated offers are listed below; some mandated offers are standardly included in UnitedHealthcare plans.

Please use the checkboxes below to indicate your acceptance or rejection of each "mandated offer".

☐ Accept ☐ Reject	[Alcohol & Drug Dependency]	[Optional coverage for treatment of alcohol and drug dependency, at a level not less than that for physical illness generally. Arkansas Statute 23-79-139]
☐ Accept ☐ Reject	[Dental Point of Service]	[Any plan that provides dental benefits must also offer a point-of-service option that provides benefits through dentists who are not members of the network.]
☐ Accept ☐ Reject	[Hospice Care]	[Optional coverage for hospice facilities and programs, at the same benefit level as provided by Medicare. Arkansas Statute 23-79-140]
☐ Accept ☐ Reject	[Mammography Screening]	[Optional coverage for mammogram screenings at various ages. Arkansas Statute 23-79-140]
☐ Accept ☐ Reject	[Mental Illness]	[Coverage for conditions arising from mental illness must be provided at specified minimum benefit levels. Arkansas Statute 23-86-113]
☐ Accept ☐ Reject	[Musculosketal Disorders]	[Optional coverage for musculoskeletal disorders of the face, neck or head. Arkansas Statute 23-79-150]
☐ Accept ☐ Reject	[Out-Patient Services]	[If a plan covers certain specified medical services on an inpatient basis, coverage must also be provided when rendered on an outpatient basis. Arkansas Statute 23-86-108(5)(a)]

Insured Group Application

UnitedHealthcare®
A UnitedHealth Group Company

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**

Requested Effective Date _____

General Information

Group's Legal Name

Street Address			Tax ID	
City		State	Zip Code	County
Contact Person	Telephone	Fax	Email Address	

Participation

Applying for: ☐ Medical ☐ Dental ☐ Vision ☐ Other _____

Disclosure

The Group certifies that the information provided above is complete and accurate. The Group shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of participants, including the addition of any newly eligible participants. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of participants in providing coverage under the policy/policies for which application is being made.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the health benefit plan(s) indicated on this Application may be transmitted electronically to me and to the Group's participants.

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Upon receipt by UnitedHealthcare and Affiliates of this signed group application and payment of the required policy charges, the group policy is deemed executed.

UnitedHealthcare disclosure regarding producer compensation:
*We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and click on the drop down box for employers under "View Our Programs – Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your producer. As of the date of this application, producer compensation shall not be paid directly related to this program, unless both the Group and UnitedHealthcare mutually agree to such compensation.

Signature (Form must be signed)

Group Signature _____ **Date** _____ **Title**_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Coverage provided by "UnitedHealthcare and Affiliates":
Medical, dental, and vision coverage provided by United HealthCare Insurance Company

Enrollment Application

UnitedHealthcare
A UnitedHealth Group Company

A. Your Information (on behalf of the enrolling dependent minor child)

Last Name	First Name	MI	Social Security Number	Home Phone Work Phone

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth / /	Sex ☐ M ☐ F	Relationship ☐ Mother ☐ Father ☐ Other _____

B. Dependent Child Information

List All Enrolling (Attach sheet if necessary)

Last Name	First Name	MI	Sex	Relationship	Birthdate	Social Security Number
			M F			– –
Last Name	First Name	MI	Sex	Relationship	Birthdate	Social Security Number
			M F			– –
Last Name	First Name	MI	Sex	Relationship	Birthdate	Social Security Number
			M F			– –
Last Name	First Name	MI	Sex	Relationship	Birthdate	Social Security Number
			M F			– –

C. Product Selection

Please indicate plan enrolling in

Plan Option _____

D. Court Order

List the court number if available

_____ State of Child Support Case _____

E. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by a physician or me or medical expenses which have been incurred may not be covered by the health benefit plan.

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I am responsible for all premiums due and owing in connection with the health benefit plan. I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

I acknowledge that, if signing below as the non-custodial parent, all information relating to the benefit plan, including but not limited to identification cards and explanation of benefit documents, shall be provided to the custodial parent or other legal guardian.

Date	Your Signature (on behalf of enrolling dependent minor child)

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____

Coverage provided by "UnitedHealthcare and Affiliates"
Medical, dental and vision coverage provided by United HealthCare Insurance Company

IMPORTANT INFORMATION

In order to make choices about health care coverage and treatment, we believe that it is important to understand how the plan operates. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, the Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or at the toll-free Customer Care number located on the back of the identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan. That means:
   - We make decisions about whether the health benefit plan selected will reimburse for care that may be received.
   - We do not decide what care is needed or will be received. You and the provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to the plan.
3. We may use individually identifiable information to identify procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with a physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to the provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for my child/children.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding the health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

Certificate of Coverage

[Child Support Insurance Solution - HealthBright^{SM} Choice Plus]

[United HealthCare Insurance Company]

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between [United HealthCare Insurance Company] and the Enrolling Group to provide Benefits to Subscribers, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Premiums.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of the *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Premiums are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Arkansas. The Policy is governed by the laws of the State of Arkansas.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to [United HealthCare Insurance Company].

When we use the words "you" and "your," to describe the rights to Benefits under the Policy, we are referring to people who are Subscribers, as that term is defined in *Section 9: Defined Terms*. When we use the words "you" and "your" to describe responsibilities under the Policy, we are also referring to the parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber and/or the parent(s) or guardian(s) who enroll the Subscriber for coverage under the Policy.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

If we fail to provide you with reasonable and adequate service, you should feel free to contact the Arkansas Insurance Department at:

Arkansas Insurance Department

[Consumer Services Division]

[1200 West Third Street]

[Little Rock, AR 72201-1904]

[(800) 852-5494] or [(501) 371-2640]

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber as that term is defined in *Section 9: Defined Terms*.
- You must pay the required Premiums.

We are entitled to reimbursement of attorney's fees and any other costs related to collecting delinquent Premiums.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

[1]*Include if reimbursement policies will be available online (should track standard 2007 determination about posting online).*

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with

Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider [[1]by going to [www.myuhc.com] or] by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

Certificate of Coverage Table of Contents

]

Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Subscriber and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).

[1]*Include when an Annual Maximum Benefit applies.*

- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services[[1], any Annual Maximum Benefit,] and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Include when group purchases benefits for clinical trials.

[[2.] Clinical Trials]

[Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.

Include to support expanding clinical trial benefit to other diseases or disorders.

- [Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.]

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Subscriber is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - *Department of Defense (DOD)*.
  - *Veterans Administration (VA)*.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.]

Include when group purchases CHD benefit.

[[3.] Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.]

Include when group purchases accidental dental benefit.

[[4.] Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

Include when group purchases plan with coverage for Diabetes Service. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[[5.] Diabetes Services]

[Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy

services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Subscribers with diabetes.

Diabetic Self-Management Items

Include paragraph below when group purchases the drug rider.

[1]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Subscriber. [[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

Include paragraph and bulleted list below when group does not purchase the drug rider.

[1]Include only when group does not purchase benefits for durable medical equipment.

[2]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps [[1]that are not fully implanted into the body,] and supplies for the management and treatment of diabetes, based upon the medical needs of the Subscriber including, but not limited to:

- [[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]**]**

Include when group purchases durable medical equipment benefit.

[6.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.

- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

Include when DME Benefit is tiered and tiers are not to be included in COC.

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card.]

Include when DME Benefit is tiered and tiers are to be included in COC.

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps.
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[7.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Include if plan design includes retrospective review of emergency services.

[Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.]

[8.] Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[[9.] Hospice Care]

[Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the Subscriber is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.]

[10.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.

- Room and board in a Semi-private Room (a room with two or more beds).

[1]*Include if RAPLs and consulting physicians are paid under the facility charge.*

- [[1]Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[2]*Include if RAPLs and consulting physicians are paid under the Physician fee category.*

- [[2]Emergency room Physicians. (Benefits for all other Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.)]

[11.] Lab, X-Ray and Diagnostics - Outpatient

[1]*Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.*

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office] include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

[2]*Include if RAPLs are paid under the facility charge.*

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]*Include if RAPLs are paid under the Physician fee category.*

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]*Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.*

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

[12.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[1]*Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.*

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

[2]*Include if RAPLs are paid under the facility charge.*

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

Include when group purchases plan with inpatient/intermediate MH/SA benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq. Remove entire benefit if group purchases MH full parity.

[[13.] Mental Health and Substance Abuse Services - Inpatient and Intermediate]

[Mental Health and Substance Abuse Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

[1]Include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care.

The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as partial hospitalization or intensive outpatient programs) or Transitional Care at the discretion of the Mental Health/Substance Abuse Designee.

One Inpatient day is equivalent to:

[2]Include first bullet only if customer purchases inpatient conversion to residential treatment.

- [[2]One day of residential treatment.]
- Two sessions of partial hospitalization/day treatment.
- Five sessions of intensive outpatient treatment.
- Six outpatient visits.
- Ten days of Transitional Care (either sober living or transitional living arrangements).]

Mental Health and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health or Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Mental Health and Substance Abuse Services.]

Include when group purchases plan with outpatient MH/SA benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq. Remove entire benefit if group purchases MH full parity.

[[14.] Mental Health and Substance Abuse Services - Outpatient]

[Mental Health and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health, substance abuse and chemical dependency evaluations and assessment.
- Diagnosis.

- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Referrals to a Mental Health or Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health and Substance Abuse Services.]

Include when group purchases benefits for ostomy supplies.

[[15.] Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.]

[16.] Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Subscriber's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Include only when benefits are tiered for Pharmaceutical Products.

[Pharmaceutical Products are assigned to various tiers. The *PDL Management Committee* makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether notification requirements should apply. Economic factors may include, but are not limited to, the Pharmaceutical Product's acquisition cost including, but not limited to, available rebates, and assessments on the cost effectiveness of the Pharmaceutical Product.]

[17.] Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

[18.] Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services for Preventive Care provided in a Physician's office are described under *Preventive Care Services*.

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.

[[1]Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.]

[2]Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.

[[2]When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[1]Include when full Maternity Services benefits are sold.

[2]If Maternity Services benefits are excluded, Complications of Pregnancy must always be included.

[19.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]

[1]Include #1 below when Benefits are available for full Maternity Services and delete option #2 further below.

[[1]Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.]

[2]Include #2 below when Benefits are available only for Complications of Pregnancy and delete option #1 above.

[[2]Benefits for Complications of Pregnancy include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

Both before and during a Pregnancy, Benefits are provided for the services of a genetic counselor when provided or referred by a Physician. Covered Health Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

[20.] Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

Physician office services:

- Routine physical examinations.
- Well baby and well child care.
- Immunizations.
- Hearing screening.

Lab, X-ray or other preventive tests:

- Screening mammography.
- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening.
- Prostate cancer screening.
- Bone mineral density tests.

Include when group purchases benefits for prosthetic devices.

[21.] [Prosthetic Devices]

[External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.]

[22.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Subscriber may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Coverage is provided for at least a minimum of 48 hours for the Hospital - Inpatient Stay related to the mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[1]Include when group purchases plan with coverage for only speech therapy or when only speech therapy and chiropractic treatment are purchased. Speech therapy is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[2]Include when group purchases benefits for chiropractic treatment.

[3]Include when group purchases benefits for rehabilitation services benefits in addition to mandated speech therapy.

[[23.] Rehabilitation Services - Outpatient [1Speech]Therapy [2and Chiropractic Treatment]]

[Short-term outpatient rehabilitation services, limited to:

- [3Physical therapy.
- Occupational therapy.]
- [2Chiropractic Treatment.]
- [1Speech therapy for loss or impairment of speech.]
- [3Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.]

[24.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[1]Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

[25.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

- [[1]Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

- [[2]Benefits for Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.]

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Subscribers who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

[26.] Surgery - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical* Services.]

[4]Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[27.] Therapeutic Treatments - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office], including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.

- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

[2]Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.

[[2]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[28.] Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

[29.] Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Include when group purchases benefits for vision exams.

[[30.] Vision Examinations]

[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

[1]Include if there are any special state requirements (mandates, etc.) which have been included.

[2]Include to indicate which state requires the special state requirements.

[[1]Additional Benefits [[2]Required By Arkansas Law]]

Include when group purchases plan with coverage for Dental Services - Anesthesia and Hospitalization. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[[31.] Dental Services - Anesthesia and Hospitalization]

[Covered Health Services for anesthesia and related hospital services in conjunction with a dental procedure, if the anesthesia and related hospital services are deemed medically necessary by the patient's Physician or dentist and the following conditions are met:

- The patient is a child age seven or younger who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- The patient is diagnosed with a serious mental or physical condition or a significant behavioral problem as determined by the patient's Physician.]

Include when group purchases plan with coverage for Medical Foods. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[[32.] Medical Foods]

[Coverage for Medical Foods and Low Protein Modified Food Products which are for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism and administered under the direction of a Physician is provided if the cost of the Medical Foods and Low Protein Modified Food Products for an individual or a family with a dependent person or persons exceeds the $2,400 per year, per person income tax credit. If the cost of these products does not exceed the per person income tax credit, coverage is not provided.]

Include when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[[33.] Mental Health Services - Inpatient and Intermediate]

[Mental Health Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Mental Health Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Mental Health Services.]

Include when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[[34.] Mental Health Services - Outpatient]

[Mental Health Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).

- Crisis intervention.

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health Services.]

This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[[35.] Musculoskeletal Disorders of the Face, Neck or Head]

[Diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment will also include both surgical and non-surgical procedures. Coverage will be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.]

Include when group purchases plan with inpatient/intermediate SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[[36.] Substance Abuse Services - Inpatient and Intermediate]

[Substance Abuse Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

[1]*Include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care.*

The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as partial hospitalization or intensive outpatient programs) or Transitional Care at the discretion of the Mental Health/Substance Abuse Designee.

One Inpatient day is equivalent to:

[2]*Include first bullet only if customer purchases inpatient conversion to residential treatment.*

- [[2]One day of residential treatment.]
- Two sessions of partial hospitalization/day treatment.
- Five sessions of intensive outpatient treatment.
- Six outpatient visits.
- Ten days of Transitional Care (either sober living or transitional living arrangements).]

Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Substance Abuse Services.]

Include when group purchases plan with outpatient SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[[37.] Substance Abuse Services - Outpatient]

[Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Substance abuse and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Referrals to a Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Substance Abuse Services.]

Include when group purchases plan with coverage for Temporomandibular Joint Services. This is a mandated benefit in Arkansas, but it can also be excluded in accordance with AR statute 23-79-801, et seq.

[[38.] Temporomandibular Joint Services]

[Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies, and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations, and TMJ implants.]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.

[2]Include when group purchases benefits for chiropractic treatment.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [[2]Chiropractic Treatment and] osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

[1]Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits.

[2]Include when group purchases accidental dental benefits. [3] Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits. [4]Include when group purchases dental anesthesia and hospitalization benefits. and hospitalization benefits.

[[1]This exclusion does not apply to [[2]accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only*] [[3]or] [[4]dental services for which Benefits are provided as described under *Dental Services - Anesthesia and Hospitalization*, in *Section 1: Covered Health Services*.]

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

[1]Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits.

[2]Include when group purchases accidental dental benefits. [3] Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits. [4]Include when group purchases dental anesthesia and hospitalization benefits. and hospitalization benefits.

[[1]This exclusion does not apply to [[2]accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only*] [[3]or] [[4]dental services for which Benefits are provided as described under *Dental Services - Anesthesia and Hospitalization*, in *Section 1: Covered Health Services*.]

[1]Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits.

[2]Include when group purchases accidental dental benefits. [3] Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits. [4]Include when group purchases dental anesthesia and hospitalization benefits. and hospitalization benefits.

3. Dental implants, bone grafts, and other implant-related procedures. [[1]This exclusion does not apply to [[2]accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only*] [[3]or] [[4]dental services for which Benefits are provided as described under *Dental Services - Anesthesia and Hospitalization*, in *Section 1: Covered Health Services*.]
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Home coagulation testing equipment.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
   - Ventricular assist devices.
4. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
5. Oral appliances for snoring.

Include when the group purchases benefits for prosthetics and delete variable exclusion #6 further below.

[6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.]

Include when the group purchases benefits for prosthetics.

[7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.]

Include when group does not purchase benefits for prosthetics and delete the variable exclusions #6 and 7 above.

[6.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

1. Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

Include when the group purchases benefits for clinical trials.

[This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.]

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Subscribers with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Subscribers who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

[1]Include when group does not purchase benefits for durable medical equipment.

G. Medical Supplies [[1]and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

Include when group does not purchase benefits for ostomy supplies.

   - [Ostomy supplies.]

This exclusion does not apply to:

Include only when group purchases benefits for durable medical equipment.

   - [Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.]
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

Include only when group purchases benefits for ostomy supplies.

   - [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

[1]Include only when group purchases benefits for durable medical equipment.

2. Tubings and masks [[1]except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

Include when group does not purchase benefits for durable medical equipment.

[3. Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health/Substance Abuse

When group purchases MH/SA coverage, keep exclusions 1-8 and delete exclusion #9. When group does not purchase MH/SA coverage, keep exclusions 6 (except for the text variable) and 9, delete all remaining exclusions (1 - 5, 7 and 8).

[1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* manual or in the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association*.]

[1]Include if group purchases MH benefits.

[2]Include if group purchases SA benefits.

[3]Include if group purchases MH and SA benefits.

[2. [[1]Mental Health Services] [[3]and] [[2]Substance Abuse Services] that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.]

[3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.]

[4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.]

[5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]

[4]Delete when group does not purchase MH/SA benefits.

[6.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements [[4], unless authorized by the Mental Health/Substance Abuse Designee].

[5]Include the following if conversion from inpatient to residential treatment is not selected.

[[5]7. Residential treatment services.]

[8. Services or supplies for the diagnosis or treatment of [[1]Mental Illness][[2], alcoholism or substance abuse] disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:

- Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Include when plan does not include MH/SA benefits.

[6]Include when the group provides MH/SA benefits under a separate plan.

[9. Services for the treatment of [[1]mental illness or mental health conditions] [[3]and] [[2]substance abuse services and chemical dependency services] [[6]that the Enrolling Group has elected to provide through a separate benefit plan].]

I. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

[1]Include when group purchases plan with coverage for Medical Foods. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

2 Enteral feedings, even if the sole source of nutrition. [[1]This exclusion does not apply to Medical Foods for which Benefits are provided as described in *Section 1: Covered Health Services*.]

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

J. Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters, dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
   - Electric scooters.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.

- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Speech generating devices.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

7. Wigs regardless of the reason for the hair loss.

Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion. (Also modify Section 9 by deleting definitions of Continuous Creditable Coverage and Preexisting Condition.)

[L. Preexisting Conditions]

[1]This paragraph will be included when group chooses to apply a 12 months preexisting condition exclusion to all Subscribers.

[1. [1]Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months.

This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

[M.] Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.

2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Include when group does not purchase rehabilitation services benefits, except when only speech therapy or when only speech therapy and chiropractic treatment are purchased. [1]Speech Therapy is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[4. Outpatient rehabilitation services. Examples include physical therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, chiropractic treatment, post-cochlear implant aural therapy and vision therapy. [[1]This exclusion does not apply to speech therapy for which Benefits are provided as described in *Section 1: Covered Health Services*.]

[5.] Psychosurgery.

[6.] Sex transformation operations.

[7.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

[8.] Biofeedback.

Include when group purchases rehabilitation services benefits that do not include chiropractic treatment.

[9. Chiropractic treatment (the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

[1] Include if group does not purchase TMJ Services. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq. Delete #2.

[2] Include if group purchases TMJ Services. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq. Delete #1.

[10.] [[1]Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.] [[2]The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis;

computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.]

[1] Include if group does not purchase TMJ Services. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[2]Include if group purchases mandated benefit for TMJ and/or optional benefit for Musculoskeletal Disorders.

[3]Include if group purchases TMJ Services. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[4]Include if group purchases both TMJ services and Musculoskeletal Disorders.

[5]Include if group purchases Musculoskeletal Disorders.This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[11.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery jaw alignment[[1] and treatment for the temporomandibular joint], except as a treatment of obstructive sleep apnea. [[2]This exclusion does not apply to [[3]*Temporomandibular Joint Services* for which Benefits are provided as described in *Section 1: Covered Health Services under Additional Benefits Required By Arkansas Law* [[4]or to][[5]services for treatment of *Musculoskeletal Disorders of the Face, Neck or Head* for which Benefits are provided as described in *Section 1: Covered Health Services* under *Additional Benefits Required By Arkansas Law*]].

[12.] Surgical and non-surgical treatment of obesity.

[13.] Stand-alone multi-disciplinary smoking cessation programs.

[N.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.
4. Foreign language and sign language interpreters.

[1]Remove all bracketed text to provide benefits for voluntary sterilization, pregnancy termination, and contraceptive supplies and other services. For groups that choose to modify, remove brackets as applicable to describe which of these services the group has chosen to exclude.

[O.] Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

[4.] The reversal of voluntary sterilization [[1]and voluntary sterilization].

[[5.] [1]Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[[6.] [1]Contraceptive supplies and services.]

[[7.] [1]Fetal reduction surgery.]

Include the following if group is not purchasing full Maternity Services but is purchasing Complications of Pregnancy only.

[[8.] Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

[P.] Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [[1]Mental Illness] [[2]mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

[Q.] Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

Include exclusion #4 when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.

[4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

[R.] Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

[S.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care.
3. Domiciliary care.
4. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:
   - No skilled services are identified.
   - Skilled nursing resources are available in the facility.
   - The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

[T.] Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.

Include when group does not purchase benefits for vision exams.

[2. Routine vision examinations, including refractive examinations to determine the need for vision correction.]

[3.] Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

[4.] Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

[5.] Eye exercise therapy.

[6.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

[U.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
8. Autopsy.

Section 3: When Coverage Begins and Premiums

How to Enroll

The parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Eligible Person must complete an enrollment form. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

We and the Enrolling Group determine who is eligible to enroll under the Policy. Please note that if you were a Subscriber under the Policy and your coverage ended because you failed to pay Premium, you will not be considered eligible to re-enroll under the Policy until both of the following are met:

- All Premium owed for prior coverage has been paid to us.
- Three months has passed since the last day of prior coverage.

Eligible Person

An Eligible Person is a child for whom medical coverage is required under a Medical Child Support Order and who meets the eligibility rules that we and the Enrolling Group establish. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not be enrolled.

New Eligible Persons

Coverage for a new Eligible Person begins on the date agreed to by the Enrolling Group and us if we receive the completed enrollment form and any required Premium.

Include the following paragraph only when two months' Premium payment is required.

[For an Eligible Person who becomes eligible after the effective date of the Policy, his or her effective date of coverage is the first day of the month following the date on which we have received at least 200% of monthly Premiums on the Eligible Person's behalf.]

Premiums

[1] *Include when either the Standard or one month Premium advance payment option applies. Delete when two months' Premium payment is required.*

All Premiums are payable by you in advance on a monthly basis. [[1]The first Premium is due and payable prior to the effective date of coverage. Subsequent] Premiums are due and payable no later than the first day of the month thereafter that the Policy is in effect.

A full month's Premium will be charged for any Subscriber who is covered under this Policy. Coverage is effective on the first of the month and ends at the end of the month. Premiums will not be prorated based upon the Subscriber's effective date or termination date of coverage. The only exception to this requirement is that a pro rata Premium, based on the number of days a Subscriber is actually covered under this Policy, will be charged for a Subscriber whose coverage is terminated due to death.

[1]Select the appropriate length of time for prior written notice, based on group requirement.

We reserve the right to change the *Schedule of Premium Rates* as described below. We will provide a [[1]31 - 120]-day prior written notice of any change in Premium.

Include when annual renewal structure applies.

[1]Insert month and date (but not the year) of the effective date of the group policy.

[When you first enroll for coverage under the Policy, the *Schedule of Premium Rates* that applies to your coverage will be in effect and will not change until the anniversary of the Enrolling Group's Policy. The anniversary of the Enrolling Group's Policy occurs each year on [[1]_____]. We reserve the right to change the Schedule of Premium Rates annually on the anniversary of the Enrolling Group's Policy.]

Include when quarterly renewal structure applies.

[When you first enroll for coverage under the Policy, the *Schedule of Premium Rates* that applies to your coverage will be in effect and will not change until the anniversary of the first day of your enrollment quarter under the Policy. We reserve the right to change the *Schedule of Premium Rates* annually on the anniversary of your enrollment quarter.

There are four enrollment quarters per calendar year: January 1 - March 31; April 1 - June 30; July 1 - September 30; and October 1 - December 31. The first day of these enrollment quarters are: January 1, April 1, July 1, and October 1.

For example, if your coverage is effective February 1, the *Schedule of Premium Rates* that applies to your coverage will be in effect and will not change until January 1 of the following year and January 1 each year thereafter that your coverage under the Policy is in effect.]

We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a material misrepresentation that resulted in the Premium rates being lower than they would have been if the material misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the material misrepresentation. For the purpose of this provision, a material misrepresentation is any oral or written communication or conduct, or combination of communication and conduct that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Include when grace period applies. Standard would be 31 days, but filed as variable to accommodate other state requirements or choice by group.

[Grace Period]

[A grace period of [31] days shall be granted for the payment of any Premium, during which time coverage under the Policy shall continue in force. If payment is not received within this [31] day grace period, coverage may be canceled after the [31st] day and the Subscriber shall be held liable for the cost of services received during the grace period.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **Failure to Pay Premium**

[1] Include when either the one or two month advance Premium options applies.

[2]Include when Standard payment option applies.

[3]Include only when two months' Premium payment option applies.

  Your coverage ends on the last day [[1]of the last calendar month for which Premium was paid in full] [[2]of the grace period, if the grace period expires and Premium remains unpaid]. [[3]Premium is considered to be paid in full when the initial two months Premium has been remitted and payment is received every month thereafter. If a monthly Premium payment is missed, coverage will terminate on the last day of the following calendar month. For example: Your coverage begins May 1 (by having paid two months Premium by April 30). If you don't submit the May Premium payment, your coverage will terminate on June 30.]

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber. Please refer to *Section 9: Defined Terms* for complete definitions of the terms Eligible Person and Subscriber.

- **We Receive Notice to End Coverage**

  Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to you that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or you knowingly gave us false material information. Examples include false information relating to eligibility.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

- The date your Inpatient Stay ends, or
- The date you have exhausted the Inpatient Stay benefits under the Policy.

Continuation of Coverage is mandated in Arkansas for a period of 120 days.

[Continuation of Coverage]

[If your coverage ends under the Policy, you are entitled to continuation coverage (coverage that continues on in some form) in accordance with state law.]

[1] *Enter the appropriate classification (State, Commonwealth, etc.)*

[2] *Enter the appropriate state name*

[3] *All references to the limiting age below are variable to allow adjustment by the State.*

[Qualifying Events for Continuation Coverage under State Law]

[Coverage must have ended due to loss of eligibility as a Subscriber because either of the following occurs:

- You are no longer subject to a *Medical Child Support Order* managed by the [[1]State of [[2]Arkansas]] in accordance with *Title IV-D of the Social Security Act.*
- You have reached the limiting age of [[3]19].]

[Electing Continuation Coverage under State Law]

[You may elect continuation coverage under state law by continuing to pay timely Premiums after either of the qualifying events above occurs.]

[Terminating Events for Continuation Coverage under State Law]

[Continuation coverage under the Policy will end on the earliest of the following dates:

- 120 days from the date coverage would otherwise have terminated due to loss of eligibility.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.

- The date coverage is or could be obtained under Medicare or any other group health plan.
- The date the Policy ends.]

Conversion is mandated and must be included in Arkansas.

[Conversion]

[If your coverage under the Policy terminates, you may be able to apply for conversion coverage without furnishing evidence of insurability. You will not be eligible for conversion if:

- The termination of coverage under the Policy results from your failure to make timely payment of the Premium.
- The entire Policy ends and is replaced by similar coverage within 31 days.
- You are eligible for Medicare coverage or full coverage under any other group accident and health policy or contract (coverage must provide benefits for all preexisting conditions to be considered full coverage).

Application and payment of the initial Premium must be made within 30 days after coverage ends under the Policy. The effective date of the converted policy is the day following the termination of the insurance under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.]

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable Annual Deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

[1]*Include the following provision and delete option #2 below if assignment of benefits is agreed to.*

[[1]If you provide written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to you. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.]

Include the following provision and delete option #1 above if assignment of benefits is not agreed to.

[[2]You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for

services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.]

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

[1]*Include if pre-service benefit notification includes determining alternate levels of benefits.*

Pre-service requests for Benefits are those requests that require notification or benefit confirmation prior to receiving medical care. [[1]If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.]

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination or post-service claim determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination.

We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see Urgent Appeals That Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Voluntary External Review Program

After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Subscriber is not an Allowable Expense.

   The following are examples of expenses or services that are not Allowable Expenses:

   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

   5. The amount of any benefit reduction by the Primary Plan because a Subscriber has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Subscribers primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim.

B. If a Subscriber is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

The Enrolling Group is solely responsible for each of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- Notifying you of the termination of the Policy.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.

- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Subscriber who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Subscriber's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

[1]Include when rebates are passed on to Subscribers. [2]Include when rebates are not passed on to Subscribers.

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We [[1]do] [[2]do not] pass these rebates on to you, [[1]and they are applied to any Annual Deductible and] [[2]nor are they applied to any Annual Deductible or] taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.

- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Subscribers

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund

Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Subscriber, that Subscriber, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Subscriber or did not legally have to be paid by the Subscriber.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Subscriber agrees to help us get the refund when requested.

If the Subscriber, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Subscriber that are payable under the

Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

[1]Include when group purchases MH coverage.

[2]Include when group purchases SA coverage.

[3]Include when group purchases MH and SA coverage.

[[1-3]An Alternate Facility may also provide [[1]Mental Health Services] [[3]or] [[2]Substance Abuse Services] on an outpatient or inpatient basis.]

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Include only when an Annual Maximum Benefit applies.

[Annual Maximum Benefit - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits*, and any attached Riders and/or Amendments.

Include when group purchase benefits for chiropractic treatment.

[**Chiropractic Treatment** -the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Include when the group purchases benefits for complications of pregnancy.

[Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period, including:

- Hospital confinement required to treat conditions, such as the following, in a pregnant female:
  - acute nephritis;
  - nephrosis;
  - cardiac decompensation;
  - HELLP syndrome;

- uterine rupture;
- amniotic fluid embolism;
- chorioamnionitis;
- fatty liver in pregnancy;
- septic abortion;
- placenta accreta;
- gestational hypertension;
- puerperal sepsis;
- peripartum cardiomyopathy;
- cholestasis in pregnancy;
- thrombocytopenia in pregnancy;
- placenta previa;
- placental abruption;
- acute cholecystitis and pancreatitis in pregnancy;
- postpartum hemmorrhage;
- septic pelvic thromboplebitis;
- retained placenta;
- venous air embolus associated with pregnancy;
- miscarriage;
- an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this subsection, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section.

- Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy:
  - hyperthyroidism,
  - hepatitis B or C,
  - HIV,
  - Human papilloma virus,
  - abnormal PAP,
  - syphilis,
  - chlamydia,
  - herpes,
  - urinary tract infections,
  - thromboembolism,
  - appendicitis,

- hypothyroidism,
- pulmonary embolism,
- sickle cell disease,
- tuberculosis,
- migraine headaches,
- depression,
- acute myocarditis,
- asthma,
- maternal cytomegalovirus,
- urolithiasis,
- DVT prophylaxis,
- ovarian dermoid tumors,
- biliary atresia and/or cirrhosis,
- first trimester adnexal mass,
- hyditidiform mole,
- ectopic pregnancy.]

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Include definition for groups that purchase Preexisting Condition exclusion.

[**Continuous Creditable Coverage** - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, [[1]Mental Illness,][[2]mental illness,] substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Subscriber, Physician, facility or any other person.
- Described in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Subscribers on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on [UnitedHealthcareOnline].

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a child who meets each of the following conditions:

Limiting age is variable to allow adjustment by the State.

- At least seven months old but less than [19] years old.
- Subject of a *Medical Child Support Order* managed by the [State of [Arkansas]] in accordance with *Title IV-D* of the *Social Security Act*.

An Eligible Person does not include a child who was previously enrolled under the Policy whose coverage ended for failure to pay Premium. Such child will not be considered eligible to re-enroll under the Policy until both of the following are met:

- All Premium owed for prior coverage has been paid to us.
- Three months has passed since the last day of prior coverage.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [[1]Mental Illness][[2]mental illness] which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolling Group - the defined or legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

Include when the group purchases benefits for clinical trials.

- [Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.]
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Include when group purchases inpatient/intermediate MH/SA benefits.

[Intermediate Care - Mental Health/Substance Abuse treatment that encompasses the following:

[1]Include the first bullet only if the customer purchases the option to convert inpatient MH/SA days to residential treatment.

- [[1]Care at a residential treatment center which provides a program of effective Mental Health/Substance Abuse treatment and meets all of the following requirements:
  - It is established and operated in accordance with any applicable state law.
  - It provides a program of treatment approved by a Physician and the Mental Health/Substance Abuse Designee.
  - It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
  - It provides at least the following basic services:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.]
- Care at a partial hospital/day treatment program, which is a freestanding or Hospital-based program that provides services for at least 20 hours per week.
- Care through an intensive outpatient program, which is a freestanding or Hospital-based program that provides services for at least nine hours per week. This encompasses half-day (i.e. less than four hours per day) partial Hospital programs.]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week; or
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Include when group purchases plan with coverage for Medical Foods. Coverage for Medical Foods is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[Low Protein Modified Food Product - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician.**]**

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

Include when group purchases plan with coverage for Medical Foods. Coverage for Medical Foods is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[Medical Food - a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.**]**

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Include when group purchases MH/SA benefits.

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *International Classification of Diseases* manual or in the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

Include when group purchases MH/SA benefits.

[Mental Health/Substance Abuse Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Policy.]

Include when group purchases MH/SA benefits.

[Mental Illness - those mental illnesses and disorders listed in the *International Classification of Diseases* manual and the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association*, unless specifically excluded under the Policy.]

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [[1]by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Include only when a per occurrence deductible applies.

[Per Occurrence Deductible - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, audiologist, certified registered nurse anesthetist, dental technician, licensed professional counselor, osteopath, psychological examiner, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Include definition if group has purchased a preexisting condition exclusion. [1]Select the appropriate "look back period."

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [[1]three] [[1]six] month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber, in accordance with the terms of the Policy.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

[[1][Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Saving Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.]

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [[1]Mental Illness][[2]mental illness] or substance abuse, regardless of the cause or origin of the [[1]Mental Illness][[2]mental illness] or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person on whose behalf the Policy is issued to the Enrolling Group. References to "you" and "your" throughout this *Certificate* to describe Benefits are references to a Subscriber. References to "you" and "your" to describe responsibilities under the Policy, are also references to the parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber and/or the parent(s) or guardian(s) who enroll the Subscriber for coverage under the Policy.

Include when group purchases MH/SA benefits.

[Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

Include when group purchases inpatient/intermediate MH/SA benefits.

[Transitional Care - Mental Health/Substance Abuse Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Subscriber with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements

may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Subscriber with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com].

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Subscriber with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Subscriber must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Use this page to create a cover if the state requires that we have a "Cover Page" to include required information.

[Child Support Insurance Solution - HealthBright^{SM} Choice Plus]

[United HealthCare Insurance Company]

[450 Columbus Boulevard]

[Hartford, Connecticut 06115-0450]

[1-800-357-1371]

ARKANSAS MANDATE DISCLOSURE NOTICE

Arkansas Statutes 23-79-801, et seq. authorizes us to offer a health insurance policy or plan which does not include all of the state mandated health benefits normally required in insurance policies or contracts in Arkansas. Examples of state mandated health insurance benefits which do not have to be included are dental anesthesia and hospitalization, in-vitro fertilization, and temporomandibular joint disorders (TMJ). The Arkansas mandated health insurance benefits not included in this health insurance policy are listed below.

Please consult your health insurance agent for information about any state health benefit that is not included in this health insurance policy. This health insurance policy may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefit coverages than those normally imposed on health insurance policies or plans in Arkansas.

If you have any questions or concerns related to the nature of any state mandated health benefit not included in this health insurance policy, please consult with:

- Your health insurance agent or
- The Arkansas Insurance Department Consumer Affairs or Legal Division.

The Arkansas mandated health benefits not included in this health insurance policy are:

- [Alcohol and Drug Dependency Treatment]
- [Ambulatory Surgical Center Coverage]
- [Children's Preventive Health Care]
- [Colorectal Cancer Screening]
- [Coverage for outpatient prescription drug or devices for use as a contraceptive]
- [Dental Point of Service Coverage]
- [Dental Anesthesia and Hospitalization]
- [Diabetes Self-Management and Training]
- [Hospice Care]
- [In-Vitro Fertilization]
- [Mammography Screening]
- [Medical Foods]

- [Mental Health Parity]
- [Musculoskeletal Disorders]
- [Off-Label Use of Drugs]
- [Speech or Hearing Impairment]
- [Temporomandibular Joint Disorders]

Certificate of Coverage

[Child Support Insurance Solution - HealthBright℠ Basics]

[United HealthCare Insurance Company]

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between [United HealthCare Insurance Company] and the Enrolling Group to provide Benefits to Subscribers, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Premiums.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of the *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Premiums are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Arkansas. The Policy is governed by the laws of the State of Arkansas.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to [United HealthCare Insurance Company].

When we use the words "you" and "your," to describe the rights to Benefits under the Policy, we are referring to people who are Subscribers, as that term is defined in *Section 9: Defined Terms*. When we use the words "you" and "your" to describe responsibilities under the Policy, we are also referring to the parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber and/or the parent(s) or guardian(s) who enroll the Subscriber for coverage under the Policy.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

If we fail to provide you with reasonable and adequate service, you should feel free to contact the Arkansas Insurance Department at:

Arkansas Insurance Department

[Consumer Services Division]

[1200 West Third Street]

[Little Rock, AR 72201-1904]

[(800) 852-5494] or [(501) 371-2640]

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber as that term is defined in *Section 9: Defined Terms*.
- You must pay the required Premiums.

We are entitled to reimbursement of attorney's fees and any other costs related to collecting delinquent Premiums.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

[1]*Include if reimbursement policies will be available online (should track standard 2007 determination about posting online).*

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with

Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider [[1]by going to [www.myuhc.com] or] by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

Certificate of Coverage Table of Contents

Section 1: Covered Health Services

Limited Benefits

This plan is a limited benefit plan. Benefits are available only for the Covered Health Services described in this *Section 1: Covered Health Services*. Benefits are limited as stated in each benefit category in the *Schedule of Benefits* and are further limited by the exclusions described in *Section 2: Exclusions and Limitations*.

Unless otherwise stated, all Benefit limits apply to any combination of Network and Non-Network Benefits. When Benefits are limited to a specific dollar amount, that dollar amount is the total maximum amount of Eligible Expenses that we will pay for the Covered Health Service per year. It does not include any Copayment or Coinsurance responsibility you may have.

You are responsible for paying any amount that exceeds the Benefit limits stated in the *Schedule of Benefits*. For Non-Network Benefits, you are also responsible for paying any amount that exceeds Eligible Expenses.

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Subscriber and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for facility-based Physicians. (Benefits for non-facility-based Physician services are described under *Physician Fees for Surgical and Medical Services - Inpatient only*.)

2. Lab, X-Ray and Diagnostics - Outpatient

Services for diagnostic purposes received on an outpatient basis at a Hospital or Alternate Facility include:

- Laboratory services.
- Mammography, radiology/X-ray (including CT scans, PET scans, MRI and MRA and other imaging studies).
- Electrocardiograms (ECG), electroencephalograms (EEG) and other diagnostic tests.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for facility-based Physicians. (Benefits are not available for non-facility-based Physician services related to *Lab, X-Ray and Diagnostics - Outpatient*.)

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services.

Include when group purchases plan with inpatient/intermediate MH/SA benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[[3.] Mental Health and Substance Abuse Services - Inpatient and Intermediate]

[Mental Health and Substance Abuse Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

[1]Include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care.

The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as partial hospitalization or intensive outpatient programs) or Transitional Care at the discretion of the Mental Health/Substance Abuse Designee.

One Inpatient day is equivalent to:

[2]Include first bullet only if customer purchases inpatient conversion to residential treatment.

- [[2]One day of residential treatment.]
- Two sessions of partial hospitalization/day treatment.
- Five sessions of intensive outpatient treatment.
- Six outpatient visits.
- Ten days of Transitional Care (either sober living or transitional living arrangements).]

Mental Health and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health or Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Mental Health and Substance Abuse Services.]

Include when group purchases plan with outpatient MH/SA benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[[4.] Mental Health and Substance Abuse Services - Outpatient]

[Mental Health and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health, substance abuse and chemical dependency evaluations and assessment.

- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Referrals to a Mental Health or Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health and Substance Abuse Services.]

5. Physician Fees for Surgical and Medical Services - Inpatient only

Physician fees for surgical procedures and other medical care received on an inpatient basis in a Hospital.

6. Physician's Office Services

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury and for Preventive Medical Care. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include lab, radiology/X-ray or other diagnostic services that are performed outside the Physician's office.

Covered Health Services for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient* above.

7. Reconstructive Procedures - Post-Mastectomy

We provide Benefits for breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Coverage is provided for at least a minimum of 48 hours for the Hospital - Inpatient Stay related to the mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level and are subject to the same limitations as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

8. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

- Physician services for facility-based Physicians. (Benefits are not available for non-facility-based Physician services related to *Surgery - Outpatient*.)

9. Trauma-Related Injuries

Benefits for Covered Health Services required as treatment for a trauma-related Injury. Covered Health Services must be provided within three days of the accident on an outpatient basis at a licensed emergency department that is located in a Hospital. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all professional fees.

Benefits under this section are not available for services required for the treatment of Sickness, mental illness or substance abuse.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care of any kind.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:

- Blood pressure cuff/monitor.
- Enuresis alarm.
- Home coagulation testing equipment.
- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.
- Ventricular assist devices.

4. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
5. Oral appliances for snoring.
6. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures - Post-Mastectomy* in *Section 1: Covered Health Services*.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in a Physician's office.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Allergy injections.

E. Emergency/Urgent Services

1. Emergency health services and urgently needed health services provided on an outpatient basis at an urgent care center, an Alternate Facility or a Hospital emergency room. This exclusion does not apply to services provided as described under *Trauma-Related Injuries* in *Section 1: Covered Health Services*.

F. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

G. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Subscribers who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

H. Home Health

1. Home health care or other care provided by a home health agency.

I. Hospice

1. Hospice care, including bereavement counseling.

J. Inpatient

1. Inpatient services including but not limited to inpatient care at a nursing home, a skilled nursing facility or inpatient rehabilitation facility. This exclusion does not apply to Covered Health Services for an Inpatient Stay in the Hospital for which Benefits are available as described in *Section 1: Covered Health Services* under the headings *Hospital - Inpatient Stay* and *Reconstructive Procedures - Post-Mastectomy*.

K. Medical Supplies and Equipment

1. Medical equipment of any kind.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.
   - Ostomy supplies.

   This exclusion does not apply to lymphedema stockings for the arms as described in *Section 1: Covered Health Services* under *Reconstructive Procedures - Post-Mastectomy.*
3. Tubings and masks.

L. Mental Health/Substance Abuse

When group purchases MH/SA coverage, keep exclusions 1-8 and delete exclusion #9. When group does not purchase MH/SA coverage, keep exclusions 6 (except for the text variable) and 9, delete all remaining exclusions (1 - 5, 7 and 8).

[1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* manual or in the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association*.]

[2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.]

[3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.]

[4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.]

[5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]

[1]Delete when group does not purchase MH/SA benefits.

[6.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements [[1], unless authorized by the Mental Health/Substance Abuse Designee].

[2]Include the following if conversion from inpatient to residential treatment is not selected.

[[2]7. Residential treatment services.]

[8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:

- Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Include when plan does not include MH/SA benefits.

[3]Include when the group provides MH/SA benefits under a separate plan.

[9. Services for the treatment of mental illness or mental health conditions and substance abuse services and chemical dependency services [[3]that the Enrolling Group has elected to provide through a separate benefit plan].]

M. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals in a Physician's office when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition.
3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

N. Outpatient

1. Outpatient therapeutic services including, but not limited to, dialysis, nuclear medicine, intravenous chemotherapy and other intravenous infusion therapy.
2. Professional services provided on an outpatient basis for non-facility-based Physicians. This exclusion does not apply to services provided in a Physician's office for which Benefits are available as described under *Physician's Office Services* in *Section 1: Covered Health Services*.

O. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters, dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
    - Electric scooters.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Mattresses.
    - Medical alert systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.
    - Pillows.
    - Power-operated vehicles.
    - Radios.
    - Saunas.
    - Stair lifts and stair glides.
    - Strollers.

- Safety equipment.
- Speech generating devices.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

P. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures - Post-Mastectomy* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures - Post-Mastectomy* in *Section 1: Covered Health Services*.
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
7. Wigs regardless of the reason for the hair loss.

Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion. (Also modify Section 9 by deleting definitions of Continuous Creditable Coverage and Preexisting Condition.)

[Q.] [Preexisting Conditions]

[1]This paragraph will be included when group chooses to apply a 12 months preexisting condition exclusion to all Subscribers.

[1. [1]Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months.

This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

[R.] Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, chiropractic treatment, post-cochlear implant aural therapy, vision therapy and cognitive therapy.
5. Psychosurgery.
6. Sex transformation operations.
7. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.
9. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
11. Surgical and non-surgical treatment of obesity.
12. Stand-alone multi-disciplinary smoking cessation programs.

[S.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.
4. Foreign language and sign language interpreters.

[1]Remove all bracketed text to provide benefits for voluntary sterilization, pregnancy termination, and contraceptive supplies and other services. For groups that choose to modify, remove brackets as applicable to describe which of these services the group has chosen to exclude.

[T.] Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

[4.] The reversal of voluntary sterilization [[1]and voluntary sterilization].

[[5.] [1]Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[[6.] [1]Contraceptive supplies and services.]

[[7.] [1]Fetal reduction surgery.]

Include the following if group is excluding coverage for maternity benefits.

[[8.] Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery). This exclusion does not apply to conditions that require treatment during a Pregnancy or during the post-partum period.]

[U.] Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [[1]Mental Illness] [[2]mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

[V.] Transplants

1. Health services for solid organ, bone marrow and stem cell transplants and transplant evaluations. The only exceptions to this exclusion are cornea transplants, bone/cartilage grafts and skin grafts.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person.

[W.] Travel

1. Health services provided in a foreign country.

2. Travel or transportation expenses, even though prescribed by a Physician, including emergency and non-emergency ambulance transportation.

[X.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.

2. Custodial Care.

3. Domiciliary care.

4. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

   - No skilled services are identified.

- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

[Y.] Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction.
3. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).
4. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.
5. Eye exercise therapy.
6. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

[Z.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
8. Autopsy.

Section 3: When Coverage Begins and Premiums

How to Enroll

The parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Eligible Person must complete an enrollment form. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

We and the Enrolling Group determine who is eligible to enroll under the Policy. Please note that if you were a Subscriber under the Policy and your coverage ended because you failed to pay Premium, you will not be considered eligible to re-enroll under the Policy until both of the following are met:

- All Premium owed for prior coverage has been paid to us.
- Three months has passed since the last day of prior coverage.

Eligible Person

An Eligible Person is a child for whom medical coverage is required under a Medical Child Support Order and who meets the eligibility rules that we and the Enrolling Group establish. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not be enrolled.

New Eligible Persons

Coverage for a new Eligible Person begins on the date agreed to by the Enrolling Group and us if we receive the completed enrollment form and any required Premium.

Include the following paragraph only when two months' Premium payment is required.

[For an Eligible Person who becomes eligible after the effective date of the Policy, his or her effective date of coverage is the first day of the month following the date on which we have received at least 200% of monthly Premiums on the Eligible Person's behalf.]

Premiums

[1]*Include when either the Standard or one month Premium advance payment option applies. Delete when two months' Premium payment is required.*

All Premiums are payable by you in advance on a monthly basis. [[1]The first Premium is due and payable prior to the effective date of coverage. Subsequent] Premiums are due and payable no later than the first day of the month thereafter that the Policy is in effect.

A full month's Premium will be charged for any Subscriber who is covered under this Policy. Coverage is effective on the first of the month and ends at the end of the month. Premiums will not be prorated based upon the Subscriber's effective date or termination date of coverage. The only exception to this requirement is that a pro rata Premium, based on the number of days a Subscriber is actually covered under this Policy, will be charged for a Subscriber whose coverage is terminated due to death.

[1]Select the appropriate length of time for prior written notice, based on group requirement.

We reserve the right to change the *Schedule of Premium Rates* as described below. We will provide a [[1]31 - 120]-day prior written notice of any change in Premium.

Include when annual renewal structure applies.

[1]Insert month and date (but not the year) of the effective date of the group policy.

[When you first enroll for coverage under the Policy, the *Schedule of Premium Rates* that applies to your coverage will be in effect and will not change until the anniversary of the Enrolling Group's Policy. The anniversary of the Enrolling Group's Policy occurs each year on [[1]_____]. We reserve the right to change the Schedule of Premium Rates annually on the anniversary of the Enrolling Group's Policy.]

Include when quarterly renewal structure applies.

[When you first enroll for coverage under the Policy, the *Schedule of Premium Rates* that applies to your coverage will be in effect and will not change until the anniversary of the first day of your enrollment quarter under the Policy. We reserve the right to change the *Schedule of Premium Rates* annually on the anniversary of your enrollment quarter.

There are four enrollment quarters per calendar year: January 1 - March 31; April 1 - June 30; July 1 - September 30; and October 1 - December 31. The first day of these enrollment quarters are: January 1, April 1, July 1, and October 1.

For example, if your coverage is effective February 1, the *Schedule of Premium Rates* that applies to your coverage will be in effect and will not change until January 1 of the following year and January 1 each year thereafter that your coverage under the Policy is in effect.]

We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a material misrepresentation that resulted in the Premium rates being lower than they would have been if the material misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the material misrepresentation. For the purpose of this provision, a material misrepresentation is any oral or written communication or conduct, or combination of communication and conduct that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Include when grace period applies. Standard would be 31 days, but filed as variable to accommodate other state requirements or choice by group.

[Grace Period]

[A grace period of [31] days shall be granted for the payment of any Premium, during which time coverage under the Policy shall continue in force. If payment is not received within this [31] day grace period, coverage may be canceled after the [31st] day and the Subscriber shall be held liable for the cost of services received during the grace period.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **Failure to Pay Premium**

[1] Include when either the one or two month advance Premium options applies.

[2]Include when Standard payment option applies.

[3]Include only when two months' Premium payment option applies.

  Your coverage ends on the last day [[1]of the last calendar month for which Premium was paid in full] [[2]of the grace period, if the grace period expires and Premium remains unpaid]. [[3]Premium is considered to be paid in full when the initial two months Premium has been remitted and payment is received every month thereafter. If a monthly Premium payment is missed, coverage will terminate on the last day of the following calendar month. For example: Your coverage begins May 1 (by having paid two months Premium by April 30). If you don't submit the May Premium payment, your coverage will terminate on June 30.]

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber. Please refer to *Section 9: Defined Terms* for complete definitions of the terms Eligible Person and Subscriber.

- **We Receive Notice to End Coverage**

  Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to you that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or you knowingly gave us false material information. Examples include false information relating to eligibility.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

- The date your Inpatient Stay ends, or
- The date you have exhausted the Inpatient Stay benefits under the Policy.

Include when Enrolling Group purchases extended coverage.

Continuation of Coverage is mandated in Arkansas for a period of 120 days. The group may elect to extend the Continuation of Coverage.

[Continuation of Coverage]

All references to the limiting age below are variable to allow adjustment by the State.

[1]Include when the 120-day Continuation of Coverage option #1 is purchased and delete option #2.

[2]When the group does not purchase option #1, delete option #1 and include option #2.

[3]Enter the appropriate classification (State, Commonwealth, etc.)

[4]Enter the appropriate state name

[[1]Continuation of coverage is available for a Subscriber who has not yet reached the limiting age of [19], but who would otherwise cease to be eligible because he or she is no longer subject to a *Medical Child Support Order* managed by the [[3]State of [[4]Arkansas]] in accordance with Title IV-D of the Social Security Act.

If this occurs, we will extend the coverage until the earlier of the following dates:

- 120 days after continuation of coverage began.
- The last day of the calendar month in which the Subscriber reaches the limiting age of [19].

Continuation of coverage is subject to continued timely payment of the required Premium and all other terms, conditions, limitations and exclusion of the Policy except those that are specifically modified in this provision.]

Include when group wants to provide continuation of coverage to children who move outside the State and/or to children who are no longer subject to a Medical Child Support Order managed by the State (with no 120-day limitation) until they reach the limiting age.

[[2]Continuation of coverage is available for a Subscriber who has not yet reached the limiting age of [19], but who would otherwise cease to be eligible because he or she is no longer subject to a *Medical Child Support Order* managed by the [[3]State of [[4]Arkansas]] in accordance with Title IV-D of the Social Security Act.]

If this occurs, we will extend the coverage until the last day of the calendar month in which the Subscriber reaches the limiting age of [19].]

Continuation of coverage is subject to continued timely payment of the required Premium and all other terms, conditions, limitations and exclusion of the Policy except those that are specifically modified in this provision.]

Conversion is mandated and must be included in Arkansas.

[Conversion]

[If your coverage under the Policy terminates, you may be able to apply for conversion coverage without furnishing evidence of insurability. You will not be eligible for conversion if:

- The termination of coverage under the Policy results from your failure to make timely payment of the Premium.
- The entire Policy ends and is replaced by similar coverage within 31 days.
- You are eligible for Medicare coverage or full coverage under any other group accident and health policy or contract (coverage must provide benefits for all preexisting conditions to be considered full coverage).

Application and payment of the initial Premium must be made within 30 days after coverage ends under the Policy. The effective date of the converted policy is the day following the termination of the insurance under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.]

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable Annual Deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

[1]*Include the following provision and delete option #2 below if assignment of benefits is agreed to.*

[[1]If you provide written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to you. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.]

Include the following provision and delete option #1 above if assignment of benefits is not agreed to.

[[2]You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for

services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.]

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

[1]*Include if pre-service benefit notification includes determining alternate levels of benefits.*

Pre-service requests for Benefits are those requests that require notification or benefit confirmation prior to receiving medical care. [[1]If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.]

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination or post-service claim determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination.

We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see Urgent Appeals That Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Voluntary External Review Program

After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Subscriber is not an Allowable Expense.

   The following are examples of expenses or services that are not Allowable Expenses:

   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

   5. The amount of any benefit reduction by the Primary Plan because a Subscriber has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Subscribers primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim.

B. If a Subscriber is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

The Enrolling Group is solely responsible for each of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- Notifying you of the termination of the Policy.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.

- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Subscriber who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Subscriber's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

[1]Include when rebates are passed on to Subscribers. [2]Include when rebates are not passed on to Subscribers.

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We [[1]do] [[2]do not] pass these rebates on to you, [[1]and they are applied to any Annual Deductible and] [[2]nor are they applied to any Annual Deductible or] taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.

- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Subscribers

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund

Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Subscriber, that Subscriber, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Subscriber or did not legally have to be paid by the Subscriber.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Subscriber agrees to help us get the refund when requested.

If the Subscriber, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Subscriber that are payable under the

Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Laboratory, diagnostic or therapeutic services.

[1]Include when group purchases MH/SA coverage. The MH/SA benefit can be excluded in accordance with AR statute 23-79-801, et seq.

[[1]An Alternate Facility may also provide Mental Health Services and Substance Abuse Services on an outpatient or inpatient basis.]

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits*, and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Include definition for groups that purchase Preexisting Condition exclusion.

[**Continuous Creditable Coverage** - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.

- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness or Injury, [[1]Mental Illness,][[2]mental illness,] [[1,2]substance abuse,] or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Subscriber, Physician, facility or any other person.
- Described in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Subscribers on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on [UnitedHealthcareOnline].

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a child who meets each of the following conditions:

Limiting age is variable to allow adjustment by the State.

- At least seven months old but less than [19] years old.
- Subject of a *Medical Child Support Order* managed by the [State of [Arkansas]] in accordance with *Title IV-D* of the *Social Security Act*.

An Eligible Person does not include a child who was previously enrolled under the Policy whose coverage ended for failure to pay Premium. Such child will not be considered eligible to re-enroll under the Policy until both of the following are met:

- All Premium owed for prior coverage has been paid to us.
- Three months has passed since the last day of prior coverage.

Enrolling Group - the defined or legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exception:

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.

- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital.

Include when group purchases inpatient/intermediate MH/SA benefits.

[Intermediate Care - Mental Health/Substance Abuse treatment that encompasses the following:

[1]Include the first bullet only if the customer purchases the option to convert inpatient MH/SA days to residential treatment.

- [[1]Care at a residential treatment center which provides a program of effective Mental Health/Substance Abuse treatment and meets all of the following requirements:
  - It is established and operated in accordance with any applicable state law.
  - It provides a program of treatment approved by a Physician and the Mental Health/Substance Abuse Designee.
  - It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
  - It provides at least the following basic services:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.]
- Care at a partial hospital/day treatment program, which is a freestanding or Hospital-based program that provides services for at least 20 hours per week.
- Care through an intensive outpatient program, which is a freestanding or Hospital-based program that provides services for at least nine hours per week. This encompasses half-day (i.e. less than four hours per day) partial Hospital programs.]

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Include when group purchases MH/SA benefits.

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *International Classification of Diseases* manual or in the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

Include when group purchases MH/SA benefits.

[Mental Health/Substance Abuse Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Policy.]

Include when group purchases MH/SA benefits.

[Mental Illness - those mental illnesses and disorders listed in the *International Classification of Diseases* manual and the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association*, unless specifically excluded under the Policy.]

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [[1]by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, audiologist, certified registered nurse anesthetist, dental technician, licensed professional counselor, osteopath, psychological examiner, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Include definition if group has purchased a preexisting condition exclusion. [1]Select the appropriate "look back period."

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [[1]three] [[1]six] month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber, in accordance with the terms of the Policy.

Preventive Medical Care - medical services aimed at early detection and intervention, focused on wellness, health promotion, and other activities that reduce the likelihood of Sickness or Injury. Preventive Medical Care includes well-baby and well-child care, routine physical examinations and screening tests, immunizations, and vision and hearing screenings.

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

[[1][Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels). When we use the [Shared Saving Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.]

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [[1]Mental Illness][[2]mental illness] or substance abuse, regardless of the cause or origin of the [[1]Mental Illness][[2]mental illness] or substance abuse.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person on whose behalf the Policy is issued to the Enrolling Group. References to "you" and "your" throughout

this *Certificate* to describe Benefits are references to a Subscriber. References to "you" and "your" to describe responsibilities under the Policy, are also references to the parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber and/or the parent(s) or guardian(s) who enroll the Subscriber for coverage under the Policy.

Include when group purchases MH/SA benefits.

[Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

Include when group purchases inpatient/intermediate MH/SA benefits.

[Transitional Care - Mental Health/Substance Abuse Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Subscriber with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Subscriber with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com].

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Subscriber with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
    - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.

- It must be performed by a Physician and in a facility with demonstrated experience and expertise.
- The Subscriber must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Use this page to create a cover if the state requires that we have a "Cover Page" to include required information.

[Child Support Insurance Solution - HealthBright[SM] Basics]

[United HealthCare Insurance Company]

[450 Columbus Boulevard]

[Hartford, Connecticut 06115-0450]

[1-800-357-1371]

ARKANSAS MANDATE DISCLOSURE NOTICE

Arkansas Statutes 23-79-801, et seq. authorizes us to offer a health insurance policy or plan which does not include all of the state mandated health benefits normally required in insurance policies or contracts in Arkansas. Examples of state mandated health insurance benefits which do not have to be included are dental anesthesia and hospitalization, in-vitro fertilization, and temporomandibular joint disorders (TMJ). The Arkansas mandated health insurance benefits not included in this health insurance policy are listed below.

Please consult your health insurance agent for information about any state health benefit that is not included in this health insurance policy. This health insurance policy may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefit coverages than those normally imposed on health insurance policies or plans in Arkansas.

If you have any questions or concerns related to the nature of any state mandated health benefit not included in this health insurance policy, please consult with:

- Your health insurance agent or
- The Arkansas Insurance Department Consumer Affairs or Legal Division.

- The Arkansas mandated health benefits not included in this health insurance policy are:
- [Alcohol and Drug Dependency Treatmentl
- [Ambulatory Surgical Center Coverage]
- [Children's Preventive Health Care]
- [Colorectal Cancer Screening]
- [Coverage for outpatient prescription drug or devices for use as a contraceptive]
- [Dental Point of Service Coverage]
- [Dental Anesthesia and Hospitalization]
- [Diabetes Self-Management and Training]
- [Hospice Care]
- [In-Vitro Fertilization]
- [Mammography Screening]
- [Medical Foods]

- [Mental Health Parity]
- [Musculoskeletal Disorders]
- [Off-Label Use of Drugs]
- [Speech or Hearing Impairment]
- [Temporomandibular Joint Disorders]

[Child Support Insurance Solution - HealthBright^{SM} Choice Plus]

[United HealthCare Insurance Company]

Schedule of Benefits

Accessing Benefits

[1]Include here and in the header for the Schedule of Benefits table if the plan design provides Designated Network Benefits in any benefit category.

You can choose to receive [[1]Designated Network Benefits,] Network Benefits or Non-Network Benefits.

[[1]Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.]

[1]Include and delete #2 if RAPLs are paid under the facility charge.

[2]Include and delete #1if RAPLs are paid under the physician fee (inpatient/outpatient) category.

[[1]Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.]

[[2]Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services, including the services of either a Network or non-Network Emergency room Physician, are always paid as Network Benefits.]

[2]Include when RAPLs are paid under the physician fee (inpatient/outpatient) category.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. [[2]Covered Health Services provided in a Network facility by a non-Network consulting Physician, anesthesiologist, pathologist and radiologist will be paid as Non-Network Benefits.]

Include when Tiered Conditional Benefits program is sold.

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change.

Depending on the geographic area and the service you receive, you may have access [[1]through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who

have not agreed to discount their charges; however, the total that you owe may be less [[1]when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a [UnitedHealthcare] Policy. As a result, they may bill you for the entire cost of the services you receive.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

Include when Benefit Activation program involving reduction in Benefits is sold.

[Benefit Activation Program]

[For certain Covered Health Services you may be required to notify us to activate the highest level of Benefits. If you fail to notify us, your Benefits will be paid at [50 - 95]% of Eligible Expenses. Benefits for which activation is required are identified in the *Schedule of Benefits* table below.]

Pre-service Benefit Confirmation

We require notification before you receive certain Covered Health Services. In general, Network providers are responsible for notifying us before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying us. Services for which you must provide pre-service notification are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:

- Ambulance - non-emergent air and ground.

Include when group purchases benefits for clinical trials.

- [Clinical trials.]

Include when group purchases benefits for congenital heart disease surgery.

- [Congenital heart disease surgery.]

Include when group purchases benefits for accident-related dental services.

- [Dental services - accidental.]

Include when group purchases plan with coverage for dental services - anesthesia and hospitalization and when notification is required. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

- [Dental services - anesthesia and hospitalization.]

Include when group purchases plan with coverage for Diabetes Services but does not purchase benefits for durable medical equipment and when notification is required. Diabetes Services is a mandated benefit in Arkansas but can be excluded in accordance with AR statute 23-79-801, et seq. [1]Include if notification applies only to insulin pumps that exceed a specific dollar amount and insert appropriate dollar amount.

- [Diabetes equipment - insulin pumps [[1]over $[1,000 - 5,000]].]

Include when group purchases benefits for DME. [1]Include if notification applies only to DME that exceeds a specific dollar amount and insert appropriate dollar amount

- [Durable Medical Equipment [[1]over $[1,000 - 5,000]].]

Include when notification is required for home health care.

- [Home health care.]

Include when group purchases plan with coverage for hospice care and notification is required for hospice care. Hospice care is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

- [Hospice care - inpatient.]

[1]Include when full maternity benefits are sold. [2]Include when complications of pregnancy benefits are sold.

- Hospital inpatient care - all scheduled admissions [[1]and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery] [[2]and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery].

Include when notification is required for Lab/X-ray.

- [Lab, X-ray and diagnostics - sleep studies.]

Include when notification is required for Lab/X-ray-Major Diagnostics.

- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine.]

Include when group purchases coverage for musculosketal disorders and notification is required. Coverage for musculoskeletal disorders is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

- [Musculoskeletal disorders of the face, neck or head.]

Include when notification is required for Pharmaceutical Products.

- [Pharmaceutical Products - IV infusions only.]

Include when group purchases benefits for prosthetics. [1]Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount

- [Prosthetic devices [[1]over $[1,000 - 5,000]].]
- Reconstructive procedures.

Include when group purchases benefits for rehabilitation services and when notification is required for any service. [1]Include when group purchases plan with coverage for only speech therapy or when only speech therapy and chiropractic treatment are purchased.Speech Therapy is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq. [2]Include when Chiropractic Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services - Outpatient [[1]Speech] Therapy [[2]and Chiropractic Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [[2]Chiropractic Treatment] [,] [and] [[1]speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy].]

Include when notification is required for scopic procedures.

- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.

Include when notification is required for outpatient surgeries.

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]].]

Include when group purchases benefits for temporomandibular joint services and notification is required. TMJ services is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

- [Temporomandibular joint services.]

Include when notification is required for outpatient therapeutics.

- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [hyperbaric oxygen therapy]].]
- Transplants.

Include paragraphs below if pre-service benefit notification includes determining alternate levels of benefits. Mental Health Benefits are mandated in Arkansas but they can be excluded in accordance with AR statute 23-79-801, et seq.

[1]Include if Mental Health Benefits are sold.

[2]Include if Mental Health Benefits are not sold.

[As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate of Coverage* under *Section 9: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, [[1]Mental Illness,] [[2]mental illness,] substance abuse or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness. After you contact us for pre-service Benefit confirmation, we will identify the Benefit level available to you.

The process and procedures used to define clinical protocols and cost-effectiveness of a health service and a listing of services subject to these provisions (as revised from time to time), are available to Subscribers on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on [UnitedHealthcareOnline].]

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time notice is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

Include when group purchases benefits for mental health/substance abuse services and when prior authorization applies to any MH/SA benefit purchased. Mental Health Benefits are mandated in Arkansas but they can be excluded in accordance with AR statute 23-79-801, et seq.

[Mental Health and Substance Abuse Services]

[Mental Health and Substance Abuse Services are not subject to the pre-service notification requirements described above. Instead, you must obtain prior authorization from the Mental Health/Substance Abuse Designee before you receive Mental Health Services and Substance Abuse Services. You can contact the Mental Health/Substance Abuse Designee at the telephone number on your ID card.]

Care Coordination[SM]

When we are notified as required, we will work with you to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the notification requirements described below do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to notify us before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

Include only when an Annual Maximum Benefit applies.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

[1]Include here and in the header for the Schedule of Benefits table if the plan design provides Designated Network Benefits in any benefit category.

When Benefit limits apply, the limit stated refers to any combination of [[1]Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
[1]Include when the Annual Deductible applies only to Non-Network Benefits. *[2]Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.* *[3]Include when there is a deductible for Designated and Network Benefits and the network and non-network amounts apply to the Designated Network and Network Annual Deductible.[4]Include bracketed Designated Network reference when Designated Network Benefits apply to any category.* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [[1]Non-Network] Benefits. [[2]The Annual Deductible applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] [[3]The Annual	*[1]Include separate Network and Non-Network headings and statements when Annual Deductible provision applies separately to Network and Non-Network Benefits and delete the combined "Network and Non-Network" provision below.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[0 - 15,000] per Subscriber.] *Include when there is no annual deductible for network benefits.* [No Annual Deductible.]

Deductible for [[4]Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.] *Include when day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* [Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.] *Include when dollar limits are reduced by the amount used toward meeting the deductible.* [Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a dollar limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the amount used toward meeting the Annual Deductible.] The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. *Include only when a per occurrence deductible applies.* [The Annual Deductible does not include any applicable Per Occurrence Deductible.]	***[[1]Non-Network]*** [$[0 - 15,000] per Subscriber.] *Include when there is no annual deductible for network benefits.* [No Annual Deductible.] *[1]Include the combined Network and Non-Network heading and statements when Annual Deductible provision applies separately to combined Network and Non-Network Benefits and delete the separate "Network" and "Non-Network" provisions above.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network,] Network and Non-Network]*** [$[0 - 15,000] per Subscriber.] *Include when there is no annual deductible for network benefits.* [No Annual Deductible.]
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.]	*[1]Include when Designated Network Benefits apply to either category.* ***[[1]Designated Network and] Network]*** *Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000]

	per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] ***[Non-Network]*** *Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$50 - 800] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.]
Out-of-Pocket Maximum	

[1]Include when OOPM includes the Annual Deductible.

[2]Include when OOPM includes the Per Occurrence Deductible.

[3]Include when OOPM includes Copayments.

[4]Include when an Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.

[5]Include when there is an OOPM for Designated and Network Benefit and the network and non-network amounts paid under the RX rider apply to the Designated Network and Network OOPM.

[6]Include bracketed Designated Network reference when Designated Network Benefits apply to any category.

The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Services provided under the *Outpatient Prescription Drug Rider*.] [[5]The Out-of-Pocket Maximum for [[6]Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.]

[7]Include only when the plan design does not apply all copayments and coinsurance to the OOPM.

[[7]Copayments and Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:

- Any charges for non-Covered Health Services.

Include bullet if notification requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.

- [The amount Benefits are reduced if you do not notify us as required.]
- Charges that exceed Eligible Expenses.
- Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.

Include bullet when an Outpatient Prescription Drug Rider is

[1]Include separate Network and Non-Network headings and statements when OOPM provision applies separately to Network and Non-Network Benefits and delete the combined "Network and Non-Network" provision below.

[2]Include when Designated Network Benefits apply to any category.

[[1][2]Designated Network and] Network]

[$[0 - 45,000] per Subscriber.]

Include when the OOPM includes the Annual Deductible.

[The Out-of-Pocket Maximum includes the Annual Deductible.]

Include when the OOPM does not include the Annual Deductible.

[The Out-of-Pocket Maximum does not include the Annual Deductible.]

Include when the OOPM includes the Per Occurrence Deductible.

[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]

Include when the OOPM does not include the Per Occurrence Deductible.

[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]

Include when there is no OOPM.

[No Out-of-Pocket Maximum.]

[[1]Non-Network]

[$[0 - 45,000] per Subscriber.]

Include when the OOPM includes the Annual Deductible.

[The Out-of-Pocket Maximum includes the Annual Deductible.]

Include when the OOPM does not include the Annual Deductible.

[The Out-of-Pocket Maximum does not include the Annual Deductible.]

Include when the OOPM includes the Per Occurrence Deductible.

[The Out-of-Pocket Maximum includes

sold and copayments/coinsurance do not apply to the overall OOPM. • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]	the Per Occurrence Deductible.] *Include when the OOPM does not include the Per Occurrence Deductible.* [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] *[3]Include combined Network and Non-Network heading and statements below when OOPM provision applies to combined Network and Non-Network Benefits and delete the separate "Network" and "Non-Network" provisions above.* *[2]Include when Designated Network Benefits apply to any category.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[0 - 45,000] per Subscriber.] *Include when the OOPM includes the Annual Deductible.* [The Out-of-Pocket Maximum includes the Annual Deductible.] *Include when the OOPM does not include the Annual Deductible.* [The Out-of-Pocket Maximum does not include the Annual Deductible.] *Include when the OOPM includes the Per Occurrence Deductible.* [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] *Include when the OOPM does not include the Per Occurrence Deductible.* [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.]
Maximum Policy Benefit	

The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	*[1]Include when separate Network and Non-Network Maximums apply.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[1,000,000 - 10,000,000] per Subscriber.] [No Maximum Policy Benefit.] ***[[1]Non-Network]*** [$[1,000,000 - 10,000,000] per Subscriber.] [No Maximum Policy Benefit.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[1,000,000 - 10,000,000] per Subscriber.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	
[The maximum amount we will pay for Benefits during the year.]	*[1]Include when separate Network and Non-Network Maximums apply* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[2,000 - 500,000] per Subscriber.] ***[[1]Non-Network]*** [$[2,000 - 500,000] per Subscriber.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[2,000 - 500,000] per Subscriber.]
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Please note that for Covered Health Services, you are responsible for paying the lesser of:	

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Benefit Limits

Include when benefit plan design has no additional limits.

[This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits* table.]

Include when benefit plan design has limits for either orthopedic or spine surgery.

[In addition to the limits stated below within the Covered Health Service categories in the *Schedule of Benefits* table, the following limits apply:]

Include when orthopedic surgery is limited.

[1]Include when orthopedic surgery is limited to a dollar amount per surgery.

[2]Include when orthopedic surgery is limited to a specific number of surgeries per lifetime.

[3]Include when orthopedic surgery is limited to both a dollar amount per surgery and a specific number of surgeries per lifetime.

- [Benefits for Covered Health Services for orthopedic surgery for joint replacement are limited to [[1]a maximum of $[5,000 - 50,000] per surgery] [[2][1 - 4] orthopedic [surgery] [surgeries] during the entire period of time a Subscriber is enrolled under the Policy] [[3]a maximum of $[5,000 - 50,000] per surgery, not to exceed [1 - 4] orthopedic [surgery] [surgeries] during the entire period of time a Subscriber is enrolled under the Policy].]

Include when spine surgery is limited.

[1]Include when spine surgery is limited to a dollar amount per surgery.

[2]Include when spine surgery is limited to a specific number of surgeries per lifetime.

[3]Include when spine surgery is limited to both a dollar amount per surgery and a specific number of surgeries per lifetime.

- [Benefits for non-emergent spine surgery, including all related services and devices, are limited to [[1]a maximum of $[5,000 - 75,000] per surgery] [[2][1 - 4] spine [surgery] [surgeries] during the entire period of time a Subscriber is enrolled under the Policy] [[3]a maximum of $[5,000 - 75,000] per surgery, not to exceed [1 - 4] spine [surgery] [surgeries] during the entire period of time a Subsriber is enrolled under the Policy].]

  This limit does not apply to:

  - Non-emergent surgeries for scoliosis or congenital defects.
  - Emergent surgeries for traumatic spine/spinal cord injury, spinal cord tumor, cauda equine syndrome, infection or neurological motor deficit.]

Include when benefits for spine surgery are provided only after conservative treatment is received.

- [Benefits for non-emergent spine surgery are available only after a Subscriber receives a minimum of a six-week course of conservative, non-surgical treatment provided under the supervision of a Physician. Benefits for spine surgery related to traumatic spine/spinal cord Injury, spinal cord tumor, cauda equine syndrome, infection, neurological motor deficit, scoliosis and congenital defects are not subject to this prior conservative, non-surgical treatment requirement.]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Pre-service Notification Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify us as soon as possible prior to transport. If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	***Network***		
Include the limit selected by the group. [Ground ambulance limited to $[500 - 5,000] per year.]	*Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. [Air ambulance limited to $[1,000 - 10,000] per year.]	*Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Non-Network*** Same as Network ***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]] ***Non-Network*** Same as Network	Same as Network [Yes] [No] [Yes] [No] Same as Network	Same as Network [Yes] [No] [Yes] [No] Same as Network
Include for groups that purchase benefits for clinical trials.			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[2.] [Clinical Trials]			

[Pre-service Notification Requirement]

[You must notify us as soon as the possibility of participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]

[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*. Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)]	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]
Include for groups that purchase benefits for congenital heart disease services. **[3.] [Congenital Heart Disease Surgeries]**	

Include if pre-service notification is required.

[1]Include if Non-Network Benefits are sold and if use of a Designated Facility is required in order to receive Network Benefits.

[Pre-service Notification Requirement]

[For Designated Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you do not notify us and if, as a result, the CHD services are not performed at a Designated Network Facility, Designated Network Benefits will not be paid.] [[1]Non-Network Benefits will apply.]]

Include when notification is required.

[1]Include applicable reduction in Benefits.

[For Non-Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you don't notify us, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses].

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include when Designated Network Benefits are available. [When performed at a Designated Facility as part of the evaluation and treatment of CHD, Covered Health Services include diagnostic services, cardiac catheterization and all non-surgical management of CHD.] *Include when CHD benefits are sold and when both Network and Non-Network Benefits are available.* [Network and Non-Network Benefits under this section include only the Congenital Heart Disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include when use of a Designated Facility is required in order to receive Network Benefits. [For Network Benefits, CHD surgeries must be received at a Designated Facility. Non-Network Benefits include services provided at a Network facility that is not a Designated Network Facility and services provided at a non-Network facility. Non-Network Benefits under this section include only the CHD surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Schedule of Benefits.] *Include when Network and Non-Network Benefits are limited and insert the limit selected by the group.* [Network and Non-Network Benefits are limited to $[30,000 - 250,000] per CHD surgery.] *Include when Non-Network Benefits are limited and insert the limit selected by the group.* [Non-Network Benefits are limited to $[30,000 - 250,000] per CHD surgery.]	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include for groups that purchase benefits for accident-related dental services. **[4.] [Dental Services - Accident Only]**			
Include when pre-service notification is required. [1]*Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For Network and Non-Network Benefits you must notify us five business days before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.) If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to $[2,000 - 5,000] per year. Benefits are further limited to a maximum of $[500 - 1,500] per tooth.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] ***[Non-Network]***	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Same as Network]	[Same as Network]	[Same as Network]
Include ONLY when group purchases plan with coverage for Diabetes Service. This is a mandated benefit in Arkansas but can be excluded in accordance with AR statute 23-79-801, et seq. **[[5.] Diabetes Services]**			

[1]*Include when the durable medical equipment benefit is sold.*

[2]*Include when the durable medical equipment benefit is not sold.*

[3]*Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.*

[4]*Include applicable reduction in Benefits or no Benefits.*

[Pre-service Notification Requirement]

[For Non-Network Benefits you must notify us before obtaining any [1]Durable Medical Equipment] [2]diabetes equipment] for the management and treatment of diabetes [3]that exceeds $[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. If you fail to notify us as required, [4]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [4]you will be responsible for paying all charges and no Benefits will be paid].]

[Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care]	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*]
[Diabetes Self-Management Items] [Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical*	***[Network]*** ***[****[1]****Include when both benefits for durable medical equipment and the outpatient prescription drug rider are sold.*** [[1]Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Equipment. *Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.* [Benefits for insulin pumps are limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]]	the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[2]Include when benefits for durable medical equipment are sold, but the outpatient prescription drug rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the outpatient prescription drug rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the outpatient prescription drug rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]**]** ***[Non-Network]***		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[1]Include when both benefits for durable medical equipment and the outpatient prescription drug rider are sold. [[1]Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* and in the *Outpatient Prescription Drug Rider*.] *[2]Include when benefits for durable medical equipment are sold, but the outpatient prescription drug rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the outpatient prescription drug rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the outpatient prescription drug rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not]		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]**]**		
Include for groups that purchase benefits for DME. **[6.] [Durable Medical Equipment]**			
[1]*Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.* [2]*Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment [1]that exceeds $[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. If you fail to notify us as required, [2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [2]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. [1]*Include either option as standard plan design.* [1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [1]Limited per year as follows: • [$[500 - 10,000] in Eligible Expenses for Tier 1.Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [$[25,001 - 100,000] in Eligible Expenses for Tier 3.] These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Always include when the DME benefit is sold. [To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.]	***[Non-Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[7.] Emergency Health Services - Outpatient			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include when benefit is limited. [Limited to $[100 - 5,000] per year.] **Note:** If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. *Include when covered health services performed at an emergency room are subject to the copayments/coinsurance stated under other benefit categories, in addition to the outpatient emergency copayment stated in this section. (This will not apply when the emergency benefit is subject to coinsurance only.)* [In addition to the Copayment stated in this section, the Copayments/Coinsurance for the following services apply when the Covered Health Service is performed as an Emergency Health Service: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic	***Network*** [[50 - 100]%] *Include bracketed provision and select either #1 or #2 if the copayment is waived.* *[1]Include as standard; [2]Include only to match prior benefit plans.* [100% after you pay a Copayment of $[5 - 300] per visit. [If you are admitted as an inpatient to a Network Hospital [[1]directly from the Emergency room] [[2]within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 300] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to chiropractic treatment when chiropractic treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Chiropractic Treatment]*.]]	***Non-Network*** Same as Network	Same as Network	Same as Network
[8.] Home Health Care			
Include if pre-service notification is required. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For Non-Network Benefits you must notify us five business days before receiving services or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
Include the limit selected by the group. [Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] [Limited to $[500 - 5,000] per year.] [Limited to [40 - 200] visits per year to a maximum of $[500 - 5,000] in Eligible	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Expenses per year.] [Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] *Include when infusion administration only is not included in the limit.* [This visit limit does not include any service which is billed only for the administration of intravenous infusion.]	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit]	[Yes] [No]	[Yes] [No]
This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq. **[[9.] Hospice Care]**			

Include if pre-service notification is required.

[1]Include applicable reduction in Benefits.

[Pre-service Notification Requirement]

[For Non-Network Benefits you must notify us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]

Include if pre-admission notification is required.

[In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]

	[Network [[50 - 100]%] [100% after you pay a Copayment of $[5 -	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	100] per day] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day]	[Yes] [No]	[Yes] [No]
[10.] Hospital - Inpatient Stay			

Include when Benefit Activation Program is sold.

[1]*Include applicable Benefit level.*

[Benefit Activation Notification Requirement]

[For Network Benefits for Covered Health Services for certain services [or as a result of certain diagnoses] you are required to notify us to activate the highest level of Benefits. If you fail to notify us, your Benefits will be paid at [[1]50 - 95]% of Eligible Expenses. You can determine the specific services [or diagnoses] for which notification is required by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[1]*Include applicable Benefit level.*

Pre-service Notification Requirement

For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.

Include if pre-admission notification is required.

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]

[1]*Include heading and row when Designated Network Benefits apply* *Include when enhanced benefits apply to specific inpatient services.* [2]*Include when Physician's fees are paid under the facility charge.* [When you choose to seek care from Designated Network facilities for certain surgical procedures [or as a result of certain diagnoses], your Benefits will be enhanced as described	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
below: • [The Copayment you pay for the facility charge [2and Physician's fees] for services provided at a Designated Network facility will be reduced to [$0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [2and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] You can determine the specific surgical procedures or diagnoses for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]		
	Network [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
[11.] Lab, X-Ray and Diagnostics - Outpatient			
Include when pre-service notification is required for sleep studies. [1]*Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For Non-Network Benefits for sleep studies, you must notify us five business days before scheduled services are received. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
[1]*Include heading and row when Designated Network Benefits apply.* *Include limit selected by group.* [Limited to $[100 - 5,000] per year.] [Non-Network Benefits are limited to $[100 - 5,000] per year.]	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
[12.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
Include when pre-service notification is required for CT, PET, MRI, MRA and nuclear medicine. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For Non-Network Benefits you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply *Include limit selected by group.* [Limited to $[100 - 5,000] per year.] [Non-Network Benefits are limited to $[100 - 5,000] per year.]	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
Include for groups that purchase inpatient and intermediate mental health/substance abuse benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
benefit, they must refuse this benefit in writing.This benefit can also be excluded in accordance with AR statute 23-79-801, et seq. Remove entire benefit if group purchases MH full parity. **[[13.] Mental Health and Substance Abuse Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] days per year.] [Non-Network Benefits for Mental Health and Substance Abuse] Services are limited to [10 - 100] days per year.] [Non-Network Benefits for Mental Health Services are limited to [10 - 100] days per year.] [Non-Network Benefits for Substance Abuse Services are limited to [10 - 100] days per year.] [Mental Health Services are limited to [10 - 100] days per year.] [Substance Abuse Services are limited to [10 - 100] days per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include for groups that purchase outpatient mental health/substance abuse benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.Remove entire benefit if group purchases MH full parity. **[[14.] Mental Health and Substance Abuse Services - Outpatient]**			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Non-Network Benefits for Mental Health and Substance Abuse Services are limited to [10 - 100] visits per year.] [Non-Network Benefits for Mental Health Services are limited to [10 - 100] visits per year.] [Non-Network Benefits for Substance Abuse Services are limited to [10 - 100] visits per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[Mental Health Services are limited to [10 - 100] visits per year.] [Substance Abuse Services are limited to [10 - 100] visits per year.]	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]	[Yes] [No]	[Yes] [No]
Include if group purchases benefits for ostomy supplies. **[[15.] Ostomy Supplies]**			
Include the limit selected by the group. [Limited to $[500 - 25,000] per year.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[16.] Pharmaceutical Products - Outpatient			
Include when notification is required for IV infusions. [1]*Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For Non-Network Benefits you must notify us five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
[1]*Include heading and row when Designated Network Benefits apply* *Include limit selected by group.* [Limited to $[100 - 5,000] per year.] [Non-Network Benefits are limited to	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
$[100 - 5,000] per year.]	Pharmaceutical Product] *Include when coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Non-Network*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[17.] Physician Fees for Surgical and Medical Services			
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [For Network Benefits for Covered Health Services [as a result of certain diagnoses or] from Physicians in the following specialties, you are required to notify us to activate the highest level of Benefits: [Cardiology,] [Cardiac/Cardio-thoracic Surgery,][Orthopedic Surgery,] [Neurosurgery,] [Allergy,] [Nephrology,] [Neurology,] [Oncology,] [Pulmonology,] [Rheumatology,] [Endocrinology,] [Infectious Disease,] [Gastroenterology,] [Obstetrics/Gynecology,] [Reproductive Endocrinology]. If you fail to notify us, your Benefits will be paid at [[1]50 - 95]% of Eligible Expenses. You can determine the specialties [or diagnoses] for which notification is required by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
[1]Include heading and row when Designated Network Benefits apply *Include when enhanced benefits apply to specific Physician services.* [When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as	***[[1]Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
identified below, your Benefits will be enhanced as described: **Specialties:** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **Enhanced Benefits:** • [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Customer Care at the telephone number on your ID card.] [2*Include text if the plan design supports paying non-network benefits for a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist).* [2Covered Health Services provided by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) in a Network facility will be paid as Non-Network Benefits.] [3*Include text if the plan design supports paying non-network benefits for a non-Network consulting Physician, assistant surgeon or surgical assistant.* [3Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]	***Network*** [50 - 100]% ***Non-Network*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[18.] Physician's Office Services - Sickness and Injury			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [For Network Benefits for Covered Health Services [as a result of certain diagnoses or] from Physicians in the following specialties, you are required to notify us to activate the highest level of Benefits: [Cardiology,] [Cardiac/Cardio-thoracic Surgery,][Orthopedic Surgery,] [Neurosurgery,] [Allergy,] [Nephrology,] [Neurology,] [Oncology,] [Pulmonology,] [Rheumatology,] [Endocrinology,] [Infectious Disease,] [Gastroenterology,] [Obstetrics/Gynecology,] [Reproductive Endocrinology]. If you fail to notify us, your Benefits will be paid at [[1]50 - 95]% of Eligible Expenses. You can determine the specialties [or diagnoses] for which notification is required by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]			
Include if group chooses to limit benefit. [1]Insert limit selected by group [Limited to [[1]2 - 10] visits per year.] *[1]Include heading and row when Designated Network Benefits apply* *Include when enhanced benefits apply to specific physician office services.* [When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be enhanced as described: **Specialties:** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.]	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
• [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **Enhanced Benefits:** • [The Copayment you pay for [the initial office visit] [[1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to $[0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [[1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 100] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.]		
Include when covered health services performed in a physician's office are subject to the copayments/coinsurance stated under other benefit categories, in addition to the office visit copayment stated in this section. (This will not apply when the office visit benefit is subject to coinsurance only.)	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 -	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance for the following services apply when the Covered Health Service is performed in a Physician's office: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] [1]*Include bracketed reference to chiropractic treatment when chiropractic treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [*[1]*and Chiropractic Treatment]*.]]	75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 100] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 -	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	100] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 100] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.]		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[1]Include Maternity Services benefit when required by state law or when group chooses to provide full maternity benefits. [2]If Maternity Services are excluded, Complications of Pregnancy must always be included. **[19.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]**			

[1]Include when benefits are provided for maternity services. [2]Include applicable Benefit level.

[[1]Pre-service Notification Requirement]

[[1]For Non-Network Benefits you must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to notify us as required, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses.]

[3]Include when benefits are provided for complications of pregnancy only. [4]Include applicable Benefit level.

[[3]Pre-service Notification Requirement]

[[3]For Non-Network Benefits you must notify us five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [[4]50 - 95]% of Eligible Expenses.]

It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

[1]Include when benefits are provided for maternity services.

[[1]Network]

[3]Include when an annual deductible applies to network benefits.

[4]Include when Network services in the Physician's office are subject to a Copayment.

[[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[[1]Non-Network] *[3]Include when an annual deductible applies to non-network benefits.* *[4]Include when Non-Network services in the Physician's office are subject to a Copayment.* [[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] *[2]Include when benefits are provided for complications of pregnancy only.* ***[[2]Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[[2]Non-Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[20.] Preventive Care Services			
Include when preventive care is limited and select the limit that applies. [Preventive care services are limited to $[100 - 1,000] per year.] **Physician office services** [Limited to [2 - 10] visits per year.] *Include ONLY when group purchases plan with coverage for children's preventive health care. This is a mandated benefit in Arkansas but can be excluded in accordance with AR statute 23-79-801, et seq.* [Well baby and well child care includes, but is not limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months,	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. No Copayment, Coinsurance or Deductible will be applicable to Network or Non-Network children's immunizations.]	office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] *[1]Include ONLY when group purchases plan with coverage for children's preventive health care. This is a mandated benefit in*	[Yes] [No] *[1]Include ONLY when group purchases plan with coverage for children's preventive health care. This is a mandated benefit in Arkansas but can be excluded in accordance with AR statute 23-79-801, et seq.* [Non-Network Benefits are not available[1] except for children under the age of 19].]	[Yes] [No] *[1]Include ONLY when group purchases plan with coverage for children's preventive health care. This is a mandated benefit in Arkansas but can be excluded in accordance with AR statute 23-79-801, et seq.* [Non-Network Benefits are not available[1] except for children under the age of 19].]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Lab, X-ray or other preventive tests:	*Arkansas but can be excluded in accordance with AR statute 23-79-801, et seq.* [Non-Network Benefits are not available[1] except for children under the age of 19].] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service] [1]*Include ONLY when group purchases plan with coverage for children's preventive health care. This is a mandated benefit in Arkansas but can be excluded in accordance with AR statute 23-79-801, et seq.* [Non-Network Benefits are not available[1] except for children under the age of 19].]	[Yes] [No] [Yes] [No] [1]*Include ONLY when group purchases plan with coverage for children's preventive health care. This is a mandated benefit in Arkansas but can be excluded in accordance with AR statute 23-79-801, et seq.* [Non-Network Benefits are not available[1] except for children under the age of 19].]	[Yes] [No] [Yes] [No] [1]*Include ONLY when group purchases plan with coverage for children's preventive health care. This is a mandated benefit in Arkansas but can be excluded in accordance with AR statute 23-79-801, et seq.* [Non-Network Benefits are not available[1] except for children under the age of 19].]
Include when group purchases benefits for prosthetic devices. **[21.] [Prosthetic Devices]**			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include if notification is required. *[1]Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.* *[2]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For Non-Network Benefits you must notify us before obtaining prosthetic devices [[1]that exceed $[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [[2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[2]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include either option as standard.* [[1]Limited to $[2,500 - 100,000] per year. Benefits are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years].] [[1]Limited per year as follows: • A maximum of $[10,000 - 30,000] per body part for each arm, leg, hand or foot. • A maximum of $[5,000 - 15,000] per body part for each eye, ear, nose, face, breast, speech aid prosthetics or tracheo-esophageal voice prosthetics. These limits include repair. Benefits for replacement are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years]. *Always include statement below except when prosthetics are not limited.* [Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[22.] Reconstructive Procedures			
[1]Include applicable Benefit level. **Pre-service Notification Requirement**			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
For Non-Network Benefits you must notify us five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Include when group does not purchase benefits for prosthetic devices.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*. *Include when group does not purchase benefits for prosthetic devices. The Benefit level inserted here must be the same as the plan coinsurance level.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply]		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	to the Out-of-Pocket Maximum.]]		
Include entire section when rehabilitation services benefit is sold. *[1]Include when group purchases plan with coverage for only speech therapy or when only speech therapy and chiropractic treatment are purchased. Speech Therapy is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.* *[2]Include when Chiropractic Treatment benefits are sold.* **[[23.] Rehabilitation Services - Outpatient [[1]Speech] Therapy [[2]and Chiropractic Treatment]]**			
Include when notification is required for any rehabilitation service. *[3]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For Non-Network Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [[2]Chiropractic Treatment] [,] [and] [[1]speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[3]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. [Limited per year as follows: • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. • [[2][10-100] visits of Chiropractic Treatment.] *Speech therapy must have the same visit limits, dollar limits, deductibles and coinsurance factors as other covered services.* • [[1][10-100] visits of speech	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
therapy.] • [10-100] visits of pulmonary rehabilitation therapy. • [10-100] visits of cardiac rehabilitation therapy. • [10-100] visits of post-cochlear implant aural therapy.] *Include when combined therapy visit limits apply.* [Any combination of outpatient rehabilitation services is limited to [10 - 160] visits per year.] *Include when combined therapy dollar limits apply.* [Any combination of outpatient rehabilitation services is limited to $[750 - 12,000] per year.] *Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* [Network Benefits for any combination of outpatient rehabilitation services are limited to [10 - 160] visits per year. Non-Network Benefits for any combination of outpatient rehabilitation services are limited to [10 - 160] visits per year.]	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit]	[Yes] [No]	[Yes] [No]
[24.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Include when notification is required for scopic procedures. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For Non-Network Benefits you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
[1]*Include heading and row when*	***[[1]Designated***		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Designated Network Benefits apply.	***Network]*** [[50 - 100]%] ***Network*** [50 - 100]% ***Non-Network*** [50 - 100]%	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
[25.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			

[1]*Include applicable Benefit level.*

Pre-service Notification Requirement

For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.

Include if pre-admission notification is required.

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]

Include limit selected by group. [Limited to [40 - 180] days per year.] [Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40 - 180] days per year.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] *Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.* [[1]100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [[1]100% after you pay a Copayment of $[50	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	- 1,000] per day to a maximum Copayment of $[50 - 5,000] per Inpatient Stay] *Variable #1 can be used only with options numbered #1 above.* [[1]If you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility, any combination of Copayments required for the Inpatient Stay in a Hospital and the Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility will apply to the stated maximum Copayment per Inpatient Stay.] [No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay]		
[26.] Surgery - Outpatient			

Include when Benefit Activation Program is sold.

[1]Include applicable Benefit level.

[Benefit Activation Notification Requirement]

[For Network Benefits for certain surgical procedures you are required to notify us to activate the highest level of Benefits. If you fail to notify us, your Benefits will be paid at [[1]50 - 95]% of Eligible Expenses. You can determine the specific surgical procedures for which notification is required by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include when notification is required.

[1]Include applicable Benefit level.

[Pre-service Notification Requirement]

[For Non-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]] you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]

[1]Include heading and row when Designated Network Benefits apply. *Include provision below when enhanced benefits apply to specific outpatient surgical services.* *[2]Include when Physician's fees are paid under the facility charge.* [When you choose to seek care from Designated Network facilities for certain surgical procedures, your	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[10 - 1,000] per date of service] [100%after you pay a Copayment of $[10 - 1,000] per date of	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Benefits will be enhanced as follows: • [The Copayment you pay for the facility charge [[2]and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [$0 - 1,000]. [The maximum reduction in Copayments is $[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [[2]and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or $[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of $[10 - 1,000].] You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]	service, to a maximum Copayment of $[10 - 5,000] per year]]		
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[100% after you pay a Copayment of $[10 - 1,000] per date of service]		[Yes, after the Per Occurrence Deductible is satisfied]
	[100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]		
	Non-Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[10 - 1,000] per date of service] [100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]		[Yes, after the Per Occurrence Deductible is satisfied]
[27.] Therapeutic Treatments - Outpatient			
Include when notification is required. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For Non-Network Benefits you must notify us [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require notification: [dialysis] [,] [and] chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [hyperbaric oxygen therapy].] If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
[1]*Include heading and row when Designated Network Benefits apply*	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[25	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	- 100] per treatment]		
[28.] Transplantation Services			

[1]*Include if Non-Network Benefits are sold.*

Pre-service Notification Requirement

For Network Benefits you must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify us and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [[1]Non-Network Benefits will apply.]

[2]*Include applicable benefit reduction penalty.*

[[1]For Non-Network Benefits you must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to notify us as required, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses.]

Include if Non-Network Benefits are sold and pre-admission notification is required.

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]

For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. *Include when Non-Network Benefits are limited and insert the limit selected by the group.* [Non-Network Benefits are limited to $[30,000 - 250,000] per transplant.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] ***Non-Network*** [[50 - 100]%] [100% after you pay	[Yes] [No] [Yes] [No] [Non-Network	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Yes] [No] [Yes, after the Per

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] [Non-Network Benefits are not available.]	Benefits are not available.]	Occurrence Deductible is satisfied] [Non-Network Benefits are not available.]
[29.] Urgent Care Center Services			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.] *Include when covered health services performed at an urgent care center are subject to the copayments/coinsurance stated under other benefit categories, in addition to the urgent care copayment stated in this section. (This will not apply when the urgent care benefit is subject to coinsurance only.)* [In addition to the Copayment stated in this section, the Copayments/Coinsurance for the following services apply when the Covered Health Service is performed at an Urgent Care Center: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[1]Include bracketed reference to chiropractic treatment when chiropractic treatment benefits are sold. • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Chiropractic Treatment].*]**]**	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.] [100% after you pay a Copayment of $[5 - 150] per visit for the first [2 - 10] visits in a year; [50 - 90]% for any subsequent visits in that year.]	[Yes] [No]	[Yes] [No]
Include when group purchases benefits for vision exams. **[[30.] Vision Examinations]**			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of [$5 -	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	75] per visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[1]*Include if there are any special state requirements (mandates, etc.) which have been included.* **[[1]Additional Benefits Required By Arkansas Law]**			
[[31.] Dental Services - Anesthesia and Hospitalization]			
[Pre-service Notification Requirement] [Any applicable notification requirements will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]			
[1]*Include heading and row when Designated Network Benefits apply*	***[[1]Designated Network]*** [Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] ***[Network]*** [Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] ***[Non-Network]*** [Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]		
[[32.] Medical Foods]			
	[1]*Include when group purchases the Outpatient Prescription Drug Rider.* ***[Network]*** [Depending upon	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	where the Covered Health Service is provided, Benefits will be [50 - 100]% [[1]or as provided under the *Outpatient Prescription Drug Rider*].] ***[Non-Network]*** [Same as Network]	[Same as Network]	[Same as Network]
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[33.] Mental Health Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
	[Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[34.] Mental Health Services -**			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Outpatient]			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
	[Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[35.] Musculoskeletal Disorders of the Face, Neck or Head]**			
[Pre-service Notification Requirement] [Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]			
[1]*Include heading and row when Designated Network Benefits apply* [Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.]	***[[1]Designated Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
Include ONLY when group purchases plan with inpatient/intermediate SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[36.] Substance AbuseServices - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] days per year.] [Non-Network Benefits are limited to [10 - 100] days per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

[*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include ONLY when group purchases plan with outpatient SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[37.] Substance Abuse Services - Outpatient]**			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Non-Network Benefits are limited to [10 - 100] visits per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated. [*The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*]			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]		
[[38.] Temporomandibular Joint Services]			

[1]*Include applicable Benefit level.*

[Pre-service Notification Requirement]

[For Non-Network Benefits you must notify us five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]

Include if pre-admission notification is required.

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]

Include the limit selected by the group. [Limited to $[1,000 - 20,000] per year.]	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.]

Eligible Expenses

[1]*Include when Designated Network Benefits apply for any Covered Health Service.*

Eligible Expenses are the amount we determine that we will pay for Benefits. For [[1]Designated Network Benefits and] Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate of Coverage*.

Include paragraph below if pre-service benefit notification includes determining alternate levels of benefits.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

[If one or more alternative health services that meets the definition of Covered Health Service in the *Certificate of Coverage* under *Section 9: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, [[1]Mental Illness,] [[2]mental illness,] substance abuse or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.]

For [[1]Designated Network Benefits and] Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a [[1]Designated Network and] Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

Include the provisions that apply for determining Eligible Expenses for Non-Network Benefits.

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:

[1]When using PHCS to determine Eligible Expenses for Non-Network Benefits, include the following and delete MNRP provisions.

  - **[**[1]For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
  - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [___]% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either of the following:
    - Reference to available CMS schedules.
    - Methods similar to those used by CMS.
  - Fee(s) that are negotiated with the provider.
  - [50 - 100]% of the billed charge.
  - A fee schedule that we develop.**]**

[2]When using MNRP to determine Eligible Expenses for Non-Network Benefits, include the following and delete PHCS provisions.

  - **[**[2]Fee(s) that are negotiated with the provider.
  - [____]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service [within the geographic market].
  - [50 - 100]% of the billed charge.
  - A fee schedule that we develop.**]**

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Continuity of Care

Continuity of care is provided under the Policy. In order for health services to be covered as Network Benefits, you must notify the company immediately if either of the following situations applies to you:

- Newly Eligible Persons who are being treated by a Non-Network provider for a current episode of an acute condition may continue to receive treatment from the Non-Network provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.
- Covered Persons who are being treated for a current episode of an acute condition by a Network provider when the provider's contract terminates may continue to receive treatment from that provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network

Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

[Child Support Insurance Solution - HealthBright℠ Basics]

[United HealthCare Insurance Company]

Schedule of Benefits

Limited Benefits

This plan is a limited benefit plan. Benefits are available only for the Covered Health Services described in the *Certificate of Coverage (Certificate)* in *Section 1: Covered Health Services*. Benefits are limited as stated in each benefit category in this *Schedule of Benefits* and are further limited by the exclusions described in the *Certificate* in *Section 2: Exclusions and Limitations*.

Unless otherwise stated, all Benefit limits apply to any combination of Network and Non-Network Benefits. When Benefits are limited to a specific dollar amount, that dollar amount is the total maximum amount of Eligible Expenses that we will pay for the Covered Health Service per year. It does not include any Copayment or Coinsurance responsibility you may have.

You are responsible for paying any amount that exceeds the Benefit limits. For Non-Network Benefits, you are also responsible for paying any amount that exceeds Eligible Expenses.

Accessing Benefits

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, pathologist and radiologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change.

Depending on the geographic area and the service you receive, you may have access [[1]through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [[1]when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a [UnitedHealthcare] Policy. As a result, they may bill you for the entire cost of the services you receive.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

Pre-service Benefit Confirmation

Include when notification is required for any service.

[1]Include when Network providers are responsible for notification for Network Benefits.

[We require notification before you receive certain Covered Health Services. [1]In general, Network providers are responsible for notifying us before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying us.] Services for which you must provide pre-service notification are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

[1]Include when the Covered Person is responsible for notification for Network Benefits.

When you choose to receive certain Covered Health Services from [[1]Network or] non-Network providers, you are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:]

Include when pre-service notification is required.

- [Hospital inpatient care - all scheduled admissions.]

Include when pre-service notification is required.

- [Reconstructive procedures - post-mastectomy.]

Include only one of options #1 - 4 below and delete the others.

[1]Include when pre-service notification requirements above are included and when the Subscriber is responsible for notification for both network and non-network services.

[[1]For all other services, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.]

[2]Include when pre-service notification requirements above are included and when Network providers are responsible for notification for Network Benefits.

[[2]For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.]

[3] Include when there are no pre-service notification requirements listed above and when Network providers are responsible for notification for Network Benefits.

[[3]When you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.]

[4]Include when no pre-service notification requirements are included above and the Subscriber is responsible for notification for both network and non-network services.

[[4]We urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health

Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.]

If you request a coverage determination at the time notice is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

Include when Maternity Services benefits are sold.

[Special Note Regarding Pregnancy]

[Benefits for Pregnancy are provided at the same level as Benefits for any other condition, Sickness or Injury.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth.]

Include when group purchases benefits for mental health/substance abuse services and when prior authorization applies to any MH/SA benefit purchased.

[Mental Health and Substance Abuse Services]

[Mental Health and Substance Abuse Services are not subject to the pre-service notification requirements described above. Instead, you must obtain prior authorization from the Mental Health/Substance Abuse Designee before you receive Mental Health Services and Substance Abuse Services. You can contact the Mental Health/Substance Abuse Designee at the telephone number on your ID card.]

Include when full Care Coordination applies to plan design.

[Care Coordination℠]

[When we are notified as required, we will work with you to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.]

Include when notification is required for any service.

[Special Note Regarding Medicare]

[If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the notification requirements described below do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to notify us before receiving Covered Health Services.]

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

The Benefit limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	

The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	***Network*** *Include when there is no annual deductible for network benefits.* [No Annual Deductible.] *Include when benefit plan design applies a per service deductible to any Covered Health Service.* [Benefits are not subject to payment of an overall Annual Deductible, however certain Covered Health Services described below in the *Schedule of Benefits* table are subject to payment of an Annual Deductible.] ***Non-Network*** *Include when there is no annual deductible for non-network benefits.* [No Annual Deductible.] *Include when benefit plan design applies a per service deductible to any Covered Health Service.* [Benefits are not subject to payment of an overall Annual Deductible, however certain Covered Health Services described below in the *Schedule of Benefits* table are subject to payment of an Annual Deductible.]
Out-of-Pocket Maximum	

The maximum you pay per year for Copayments or Coinsurance.	***Network*** No Out-of-Pocket Maximum. ***Non-Network*** No Out-of-Pocket Maximum.
Maximum Policy Benefit	
The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	***Network and Non-Network*** [$[100,000 - 2,000,000] per Subscriber.] [No Maximum Policy Benefit.]

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Benefit Limits

This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits* table.

Benefit limits apply to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***
1. Hospital - Inpatient Stay	

Include when pre-service notification is required.

[1]Include when the Subscriber is responsible for notification for Network Benefits.

[2]Include when Maternity Services benefits are sold.

[3]Include when non-notification penalty applies and the Subscriber is responsible for notification for Network Benefits.

[4]Insert a dollar amount that is 50% (or one-half) of the benefit limit stated below.

[5]Include when non-notification penalty applies and when Network providers are responsible for notification for Network Benefits.

[Pre-service Notification Requirement]

[For [1]Network and] Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including emergency admissions).] [2]For a maternity Inpatient Stay you must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the following time frames:

- At least 48 hours for the mother and newborn child following a normal vaginal delivery.
- At least 96 hours for the mother and newborn child following a cesarean section delivery.]

[3]If you fail to notify us as required, Benefits will be reduced to:

- A maximum of $[4]XXX] in Eligible Expenses per day for Covered Health Services at a Network Hospital, and
- A maximum of $[4]XXX] in Eligible Expenses per day for Covered Health Services at a non-Network Hospital.]]

[5]If you fail to notify us as required, Benefits will be reduced to a maximum of $[4]XXX] in Eligible Expenses per day for Covered Health Services at a non-Network Hospital.]

[1]Insert benefit maximums per plan design. Benefits are limited as follows: • A maximum of $[1]100 - 3,000] in Eligible Expenses per day for Covered Health Services at a Network Hospital, and • A maximum of $[1]100 - 3,000] in Eligible Expenses per day for Covered Health Services at a	***Network*** [50 - 100]%

Benefit limits apply to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.	
The maximum differential between network and non-network benefit levels is 25% per Arkansas law.	
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***
non-Network Hospital. Any combination of Network and Non-Network Benefits is limited to a maximum of [30 - 100] days per year.	***Non-Network*** [50 - 100]%
2. Lab, X-Ray and Diagnostics - Outpatient	
Benefits for outpatient diagnostic services are limited to a maximum of $[100 - 1,000] in Eligible Expenses per Subscriber per year. Network Benefits are available only when diagnostic services are performed by a Network provider.	***Network*** [50 - 100]% ***Non-Network*** [50 - 100]%
Include for groups that purchase inpatient and intermediate mental health/substance abuse benefits. **[[3.] Mental Health and Substance Abuse Services - Inpatient and Intermediate]**	
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]	
Include the limit selected by the group. Benefits are limited to [5 - 30] days per year.	***[Network]*** [[50 - 100]%]
	[Non-Network] [[50 - 100]%]
Include for groups that purchase outpatient mental health/substance abuse benefits. **[[4.] Mental Health and Substance**	

Benefit limits apply to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.	
The maximum differential between network and non-network benefit levels is 25% per Arkansas law.	
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***
Abuse Services - Outpatient]	
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]	
Include the limit selected by the group. Benefits are limited to [2 - 10] visits per year.	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]
5. Physician Fees for Surgical and Medical Services - Inpatient only	
Physician fees for services provided during an Inpatient Stay are limited to a maximum of $[100 - 3,000] in Eligible Expenses per year.	***Network*** [50 - 100]% ***Non-Network*** [50 - 100]%
6. Physician's Office Services	
• Benefits are limited to a maximum of $[100 - 1,000] in Eligible Expenses per year.	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 35] per visit] ***Non-Network*** [50 - 100]%
7. Reconstructive Procedures - Post-Mastectomy	

Benefit limits apply to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***
Include when pre-service notification is required. *[1]Include when the Subscriber is responsible for notification for Network Benefits.* *[2]Include when non-notification penalty applies and the Subscriber is responsible for notification for Network Benefits.* *[3]Insert a dollar amount that is 50% (or one-half) of the benefit limit stated below.* *[4]Include when non-notification penalty applies and when Network providers are responsible for notification for Network Benefits.*	**[Pre-service Notification Requirement]** [For [1]Network and] Non-Network Benefits for a scheduled admission, you must notify us five business days before a scheduled reconstructive procedure, or for non-scheduled procedures, as soon as is reasonably possible. [[2]If you fail to notify us as required, Benefits will be reduced to: • A maximum of $[[3]XXX] in Eligible Expenses per day for Covered Health Services at a Network Hospital, and • A maximum of $[[3]XXX] in Eligible Expenses per day for Covered Health Services at a non-Network Hospital.]] [[4]If you fail to notify us as required, Benefits will be reduced to a maximum of $[[3]XXX] in Eligible Expenses per day for Covered Health Services at a non-Network Hospital.]
Benefits for post-mastectomy breast reconstruction are subject to the Benefit limits stated under the following Covered Health Service categories in this *Schedule of Benefits*: • Hospital - Inpatient Stay. • Lab, X-Ray and Diagnostics - Outpatient. • Physician's Office Services. • Physician Fees for Surgical and Medical Services - Inpatient only. • Surgery - Outpatient. *[1]The benefit limit inserted here must be the same benefit limit that applies to Physician's Office Services.* Benefits for breast prosthesis, mastectomy bras and lymphedema	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.* For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses. ***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.* For breast prosthesis, mastectomy bras and lymphedema

Benefit limits apply to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. *The maximum differential between network and non-network benefit levels is 25% per Arkansas law.*	
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***
stockings for the arms are limited to a maximum of $[[1]100 - 1,000] in Eligible Expenses per year.	stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses.
8. Surgery - Outpatient	
[1]*Include when outpatient surgery benefits are subject to payment of an annual deductible.* [[1]Benefits are available only after you meet an Annual Deductible of $[50 - 250] per year.] Benefits for outpatient surgery are limited to a maximum of $[1,000 - 30,000] in Eligible Expenses per year.	***Network*** [50 - 100]% ***Non-Network*** [50 - 100]%
9. Trauma-Related Injuries	
[1]*Include when benefits are subject to payment of an annual deductible.* [[1]Benefits are available only after you meet an Annual Deductible of $[50 - 250] per year.] Benefits for the treatment of a trauma-related Injury are limited to a maximum of $[500 - 15,000] in Eligible Expenses per year.	***Network*** [50 - 100]% ***Non-Network*** [50 - 100]%

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider, Eligible Expenses are billed charges unless a lower amount is negotiated.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

Include the provisions that apply for determining Eligible Expenses for Non-Network Benefits.

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:

[1]When using PHCS to determine Eligible Expenses for Non-Network Benefits, include the following and delete MNRP provisions.

  - **[**Available data resources of competitive fees in that geographic area.
  - Fee(s) that are negotiated with the provider.
  - [50 - 100]% of the billed charge.
  - A fee schedule that we develop.**]**

[2]When using MNRP to determine Eligible Expenses for Non-Network Benefits, include the following and delete PHCS provisions.

  - **[**[2]Fee(s) that are negotiated with the provider.
  - [____]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service [within the geographic market].
  - [50 - 100]% of the billed charge.
  - A fee schedule that we develop.**]**

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Continuity of Care

Continuity of care is provided under the Policy. In order for health services to be covered as Network Benefits, you must notify the company immediately if either of the following situations applies to you:

- Newly Eligible Persons who are being treated by a Non-Network provider for a current episode of an acute condition may continue to receive treatment from the Non-Network provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.
- Covered Persons who are being treated for a current episode of an acute condition by a Network provider when the provider's contract terminates may continue to receive treatment from that provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Outpatient Prescription Drug Rider

[United HealthCare Insurance Company]

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms* and in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to [United HealthCare Insurance Company].

When we use the words "you" and "your" to describe the rights to Benefits under the Policy, we are referring to people who are Subscribers, as that term is defined in the *Certificate of Coverage* in *Section 9: Defined Terms*. When we use the words "you" and "your" to describe responsibilities under the Policy, we are also referring to the parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber.

Include only one of the two COB options listed below.

Include if COB does not apply to RX benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate of Coverage* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

Include if COB applies to RX benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate of Coverage* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the Certificate of Coverage.]

_____

(Name and Title)

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Subscribers as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Subscriber is a determination that is made by the Subscriber, his or her parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber, and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

[1]Include for groups that purchase the Mandatory or Restrictive Generic Program.

[2]Include when the benefit plan design includes Therapeutic Class Charge.

You may seek reimbursement from us as described in the *Certificate of Coverage* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and/or Coinsurance, [[1]Ancillary Charge,] [[2]Therapeutic Class Charge,] and any deductible that applies.

Include for groups that purchase the designated pharmacy benefit. Designated pharmacy can be utilized for more than the specialty drug program. It applies to specialty when #1 below is included.

[1]Include when benefit plan design includes specialty drug program.

[Designated Pharmacies]

[If you require certain Prescription Drug Products [1, including, but not limited to, Specialty Prescription Drug Products,] we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.]

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

[1]Include if the Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible applies. [2]Include when the Annual Drug Deductible apples. [3]Include when both Annual Drug Deductible and Specialty Prescription Drug Product Annual Deductibles apply. [4]Include when the Specialty Prescription Drug Product Annual Deductible applies. [5]Include only when plans pass rebates on to customers. [6]Include for all other plans.

We may receive rebates for certain drugs included on the Prescription Drug List [1, including those drugs that you purchase prior to meeting your [2Annual Drug Deductible] [3or] [4Specialty Prescription Drug Product Annual Deductible]]. We [5do] [6do not] pass these rebates on to you, [5and they are] [6nor are they] [1applied to your [2Annual Drug Deductible] [3or] [4Specialty Prescription Drug Product Annual Deductible] or] taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Rider. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Rider. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

[1]Contraceptives are mandated in AR, except for religious group employers or for when this mandate is not included in accordance with AR statute 23-79-801 et seq.

[2]Include for group that purchase closed-panel benefits and the corresponding exclusion is included in Section 2. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service [[1]or is prescribed to prevent conception]. [[2]Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Include when plan includes Specialty Drug Program.

[Specialty Prescription Drug Products]

[Benefits are provided for Specialty Prescription Drug Products.

[1]Include for groups that purchase Designated Pharmacy benefit.

[[1]If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.]

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product [[1]and Designated Pharmacy].

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.]

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in *Section 5* of your *Certificate of Coverage*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Include for groups that purchase the mail order benefit option.

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.]

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate of Coverage* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate of Coverage* is not applicable to this Rider. In addition, the following exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

[1]Remove only when Enrolling Group requests coverage for non-Emergency drugs dispensed outside the U.S.

[[1]2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.]

[3.] Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.

[1]Remove when this mandate is not included in accordance with AR statute 23-79-801 et seq.

[4.] Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. [[1]This exclusion will not apply to Prescription Drug Products approved by the *United States Food and Drug Administration (USFDA)* for use in the treatment of cancer on the basis that the Prescription Drug Product has not been approved by the *USFDA* for the treatment of the specific type of cancer for which the Prescription Drug Product has been prescribed, provided:

- the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more compendia:
  - the *American Hospital Formulary Service Drug Information*;
  - the *United States Pharmacopoeia Dispensing Information*; or
- the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature that have not had their recognition of the Prescription Drug Product's safety and effectiveness contraindicated by clear and convincing evidence in another article from medical literature.

  Medical literature is defined as articles from major peer reviewed medical journals specified by the *United States Department of Health and Human Services*.]

[5.] Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

[6.] Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Remove exclusion for plans that provide coverage for weight loss products.

[[7.] Any product dispensed for the purpose of appetite suppression or weight loss.]

[1]Contraceptives are mandated in AR, except for religious group or for when this mandate is not included in accordance with AR statute 23-79-801 et seq. [2]Include when immunizations administered in a pharmacy are covered under the Outpatient Pharmacy Rider. Select appropriate pharmacy or combination of pharmacies where coverage is provided.

[8.] A Pharmaceutical Product for which Benefits are provided in your *Certificate of Coverage*. [[1]This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [[2]This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]

[9.] Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

[10.] General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

[11.] Unit dose packaging of Prescription Drug Products.

[12.] Medications used for cosmetic purposes.

[13.] Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.

[14.] Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

[15.] Prescription Drug Products when prescribed to treat infertility.

Include for groups that do not purchase benefits for toenail fungus treatment.

[[16.] Treatment for toenail Onychomycosis (toenail fungus).]

Include for group that do not purchase benefits for smoking cessation.

[[17.] Prescription Drug Products for smoking cessation.]

Include for groups that purchase a closed benefit plan design. Delete for groups that purchase an open benefit plan design (open benefit plan provides coverage at all tier levels). Include commas and "or" as applicable to the level of Closed Benefit Plan.

[[18.] Prescription Drug Products not included on Tier-1 [,] [or] [Tier-2] [,] [or] [Tier-3] [,] [or] [Tier-4] [or] [Tier-5] of the Prescription Drug List at the time the Prescription Order or Refill is dispensed.]

Include for groups that purchased closed-panel benefits. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

[[19]. A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]

[1]Include if compounds are covered. When compound drugs are covered they are always assigned to the highest tier available under the rider. [2]Include if compounds are not covered.

[20.] [[1]Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-[2] [3] [4] [5] [6].)] [[2]Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]

Remove exclusion for plans that provide coverage for OTC drugs.

[[21.] Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

Include if Benefits are not provided for New Prescription Drug Products.

[[22.] New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by our Prescription Drug List Management Committee.]

Always include either #1 or #2. [1]Include if growth hormone therapy is excluded for any and all conditions. [2]Include if growth hormone therapy is covered for all conditions except for children with familial short stature).

[[23.] [[1]Growth hormone therapy.] [[2]Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]

Include if Benefits are not provided on any tier.

[[24.] Any oral non-sedating antihistamine or antihistamine-decongestant combination.]

Include if Benefits are not provided on any tier.

[[25.] Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]

[1]Remove when this mandate is not included in accordance with AR statute 23-79-801 et seq.

[26.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury[, except that Medical Foods and Low Protein Food Products are covered for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism if the products are prescribed and administered under the direction of a Physician].

Include when the Enrolling Group requests an exclusion for one or more Therapeutic Classes.

[[27.] A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]

Include if Benefits are not provided on any tier.

[[28.] Prescription Drug Products when prescribed as sleep aids.]

Include when benefit plan design includes Therapeutic Equivalent exclusion.

[[29.] A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.]

Include when benefit plan design includes exclusion for both a modified version and Therapeutically Equivalent drug product.

[[30.] A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.]

Section 3: Defined Terms

Include for groups that purchase the Mandatory or Restrictive Generic Program.

[1]Include for groups that purchase the Mandatory Generic Program.

[**Ancillary Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your [[1]or the provider's] request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Cost or MAC list price of the Chemically Equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Predominant Reimbursement Rate or MAC list price for non-Network Pharmacies for the Prescription Drug Product on the higher tier, and the Predominant Reimbursement Rate or MAC list price of the Chemically Equivalent Prescription Drug Product available on the lower tier.]

Include if benefit design has an Annual Drug Deductible.

[1]Include if the Annual Drug Deductible provision applies only to Tier-2, Tier-3 and Tier-4, Tier- 5 and Tier-6 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this Rider.)

[**Annual Drug Deductible** - the amount you are required to pay for covered [[1][Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and Tier-6]] Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Include if benefit design has an Annual Maximum Drug Benefit.

[**Annual Maximum Drug Benefit -** the maximum amount we will pay for Prescription Drug Products during a year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Maximum Drug Benefit applies.]

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Include if plan design includes designated pharmacy benefits and/or specialty prescription drug product benefits.

[1]Include for groups that purchase the specialty drug program.

[**Designated Pharmacy -** a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products[[1], including, but not limited to, Specialty Prescription Drug Products]. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.]

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Include when separate Copayment and/or Coinsurance option for preventive medications is used.

Include when drug rider is issued with a plan design that has a combined pharmacy and medical deductible, combined out of pocket or both and preventive medications are excepted from deductible or out of pocket maximum.

[1]Include when plan design includes Specialty Prescription Drug program

[**List of Preventive Medications -** a list that identifies certain Prescription Drug Products [[1], which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include for groups that purchase the Mandatory or Restrictive Generic Program.

[**Maximum Allowable Cost (MAC) List -** a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.]

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Subscribers.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Prescription Drug List Management Committee.
- December 31st of the following calendar year.

Include when plan design includes increased Copayments or Coinsurance when a Non-Preferred Retail Network Pharmacy is utilized.

[**Non-Preferred Retail Network Pharmacy** - a pharmacy that we identify as a non-preferred pharmacy within the Network.]

Include if Copayments and/or Coinsurance are limited by an Out-of-Pocket Drug Maximum.

[**Out-of-Pocket Drug Maximum -** the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Include when plan design includes reduced Copayments or Coinsurance when a Preferred Retail Network Pharmacy is utilized.

[**Preferred Retail Network Pharmacy** - a pharmacy that we identify as a preferred pharmacy within the Network.]

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to

which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.

[1]Include when corresponding exception for immunizations administered in a pharmacy is included in exclusion #8

- [[1]Immunizations administered in a pharmacy.]
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Include if plan includes specialty drug program.

[1]Include when definition of List of Preventive Medications is included.

[**Specialty Prescription Drug Product -** Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. [[1]Specialty Prescription Drug Products may include drugs on the List of Preventive Medications.] You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include if benefit design has a Specialty Prescription Drug Product Annual Deductible.

[1]Include if the Specialty Prescription Drug Product Annual Deductible provision applies only to Tier-2, Tier-3 and Tier-4, Tier-5 and Tier-6 Specialty Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this Rider.)

[**Specialty Prescription Drug Product Annual Deductible** - the amount you are required to pay for covered [[1][Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and Tier-6]] Specialty Prescription Drug Products in a year before we begin paying for Specialty Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Annual Deductible applies.]

Include if benefit design has a Specialty Prescription Drug Product Annual Maximum Benefit.

[**Specialty Prescription Drug Product Annual Maximum Benefit -** the maximum amount we will pay for covered Specialty Prescription Drug Products during a year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Annual Maximum Benefit applies.]

Include if Copayments and/or Coinsurance are limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.

[**Specialty Prescription Drug Product Out-of-Pocket Maximum -** the maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Out-of-Pocket Maximum applies.]

Include when benefit plan design includes Copayment, Coinsurance, ancillary charges, or exclusion by Therapeutic Class.

[**Therapeutic Class -** a group or category of Prescription Drug Products with similar uses and/or actions.]

Include when benefit plan design includes Therapeutic Class Charge.

[**Therapeutic Class Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a maximum allowable cost. For Prescription Drug Products from Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Prescription Drug Cost for Network Pharmacies for the Prescription Drug Product dispensed and the maximum allowable cost for the Therapeutic Class. For Prescription Drug Products from non-Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Predominant Reimbursement Rate for the Prescription Drug Product dispensed and the maximum allowable cost for the Therapeutic Class.]

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Outpatient Prescription Drug

[United HealthCare Insurance Company]

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Include for groups that purchase closed-panel benefits and the corresponding exclusion is included in Section 2. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Contraceptives are mandated in AR, except for religious group employers or for when this mandate is not included in accordance with AR statute 23-79-801 et seq.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service [or is prescribed to prevent conception].

If a Brand-name Drug Becomes Available as a Generic

Include for groups that purchase an Open Benefit Design.

[1]Include for groups that purchase the Mandatory or Restrictive Program.

[If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change [[1]and an Ancillary Charge may apply]. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.]

Include for groups that purchase a closed benefit design.

[1]Include for group that purchase the Mandatory or Restrictive Program.

[If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change [[1]and an Ancillary Charge may apply,] or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.]

Include for groups that purchase closed-panel benefits and the corresponding exclusion is included. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify us or our designee. The reason for notifying us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying us.

Non-Network Pharmacy Notification

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for notifying us as required.

If we are not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring notification are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

If we are not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage* in *Section 5: How to File a Claim*.

[1]Include for groups that purchase the Mandatory or Restrictive Generic Program.

[2]Include when benefit plan design includes Therapeutic Class Charge.

When you submit a claim on this basis, you may pay more because you did not notify us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance [[1], Ancillary Charge] [[2], Therapeutic Class Charge] and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

Include when programs which result in enhanced Benefits are available.

[We may also require notification for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable notification, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include when step therapy requirements apply.

[Step Therapy]

[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate of Coverage* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

What You Must Pay

[1]Include if the benefit plan design has an Annual Drug Deductible. [2]Include if the benefit plan design has an Annual Drug Deductible and a Specialty Prescription Drug Product Annual Deductible. [3]Include when the benefit plan design has a Specialty Prescription Drug Product Annual Deductible.

[You are responsible for paying the [[1]Annual Drug Deductible] [[2]and] [[3] Specialty Prescription Drug Product Annual Deductible].]

[1]Include for groups that purchase the Mandatory or Restrictive Generic Program. [2]Include when the benefit plan design includes Therapeutic Class Charge. [3]Include when #1 is removed. [4]Include when #1 remains.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table [[1], in addition to any Ancillary Charge] [[2][[3], in addition to any] [[4]or] Therapeutic Class Charge].

Include for groups that purchase the Mandatory or Restrictive Generic Program.

[1]Include for groups that purchase the Mandatory Generic Program. [2]Include when the lower tiered drug Copayment and/or Coinsurance applies. [3]Include when the higher tiered drug Copayment and/or Coinsurance applies. [4]Include for CDHPs, HSAs and HRAs if plan design has a deductible/OOPDM provision. Include the appropriate deductible provisions and OOPDM provisions based on plan design.

[An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your [[1]or the provider's] request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the [[2]lower tiered drug] [[3]higher tier drug]. [[4]An Ancillary Charge does not apply to any [Annual Drug Deductible] [,] [Specialty Prescription Drug Product Annual Deductible] [,] [or] [Out-of-Pocket Drug Maximum] [or] [Specialty Prescription Drug Product Out-of-Pocket Maximum].]]

Include when benefit plan design includes Therapeutic Class Charge.

[A Therapeutic Class Charge may apply when the Prescription Drug Cost or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the maximum amount we allow for a drug in the Prescription Drug Product's Therapeutic Class. You are responsible for the Therapeutic Class Charge and any applicable Copayment and/or Coinsurance.]

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate of Coverage*:

Include when Copayments are NOT applied to the overall OOPM in the COC. [1]Include when benefit plan design includes Specialty Drug Copayments.

- [Copayments for Prescription Drug Products [[1], including Specialty Prescription Drug Products].]

Include when Coinsurance is NOT applied to the overall OOPM in the COC. [1]Include when benefit plan design includes Specialty Drug Coinsurance.

- [Coinsurance for Prescription Drug Products [[1], including Specialty Prescription Drug Products].]

Include for groups that purchase the Mandatory or Restrictive Generic Program.

- [Ancillary Charges.]

Include when benefit plan design includes Therapeutic Class Charge.

- [Therapeutic Class Charges.]

Include if the Annual Drug Deductible provision applies, however delete if the Annual Drug Deductible is included in the Annual Deductible in the Medical COC and the OOPM in the COC includes the Annual Deductible.

- [The Annual Drug Deductible.]

Include if the Specialty Prescription Drug Product Annual Deductible provision applies, however delete if the Specialty Annual Deductible is included in the Annual Deductible in the Medical COC and the OOPM in the COC includes the Annual Deductible.

- [The Specialty Prescription Drug Product Annual Deductible.]

Include if the Annual Maximum Drug Benefit applies.

- [Any amount you pay for Prescription Drug Products that exceeds the Annual Maximum Drug Benefit.]

Include if the Specialty Prescription Drug Product Annual Maximum Benefit applies.

- [Any amount you pay for Specialty Prescription Drug Products that exceeds the Specialty Prescription Drug Product Annual Maximum Benefit.]
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

Payment Information

If group purchases a plan design with an Annual Drug Deductible provision, retain the Annual Drug Deductible provision below per that plan design.

Include Specialty Prescription Drug Product Annual Deductible provision when a separate deductible applies to Specialty Prescription Drug Products.

If group purchases an plan design with an Out-of-Pocket Drug Maximum, include Out-of-Pocket Drug Maximum.

If group purchases a plan design with a Specialty Prescription Drug Product Out-of-Pocket Maximum, include the Specialty Prescription Drug Product Out-of-Pocket Maximum.

If group purchases a plan design with an Annual Maximum Drug Benefit, include Annual Maximum Drug Benefit.

If group purchases a plan design with a Specialty Prescription Drug Product Annual Maximum Benefit, include the Specialty Prescription Drug Product Annual Maximum Benefit.

[The Annual Drug Deductibles are calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Annual Deductibles are calculated on a [calendar] [Policy] year basis.]

[The Out-of-Pocket Drug Maximums are calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

[The Annual Maximum Drug Benefit is calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Payment Term And Description	Amounts
[Annual Drug Deductible]	
Select either Option 1 or Option 2, if there is an Annual Drug Deductible. *Option 1: Include the following paragraph and corresponding deductible language if application of the Annual Drug Deductible is determined based on Network or Non-Network status.* *[1]Include if the Annual Drug Deductible provision applies only to Tier-2, Tier-3, Tier-4, Tier-5 and/or Tier-6 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this rider.)* *[2]Include if the Annual Drug Deductible applies only to Network Benefits.* *[3]Include if the Annual Drug Deductible applies only to Non-Network Benefits.* [4] *Include if the Annual Drug Deductible applies to both Network and Non-Network Benefits. Select options in table*	*The option below corresponds with Option 1.* *Insert deductible amounts according to benefit design chosen by group.* ***[[2]Network]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] ***[[3]Non-Network]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] ***[[4]Network and Non-Network]*** *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] *The options below correspond with Option 2.*

Payment Term And Description	Amounts
accordingly. [The amount you pay for covered [[1][Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and Tier-6]] Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4]at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.] *Option 2: Include the following paragraph and corresponding deductible language when the application of the Annual Drug Deductible is determined based on tier status.* *[1]Include the tiers that the Annual Drug Deductible provision applies to: Tier-1, Tier-2, Tier-3, Tier-4, Tier-5 and/or Tier-6 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this Rider.) [2]Include if the Annual Drug Deductible applies only to Network Benefits. [3]Include if the Annual Drug Deductible applies only to Non-Network Benefits. [4] Include if the Annual Drug Deductible applies to both Network and Non-Network Benefits.* [The amount you pay for covered [[1][Tier-1] [,] [Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and] [Tier-6]] Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4]at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.]	*Included appropriate Tiers based on plan design. Insert deductible amounts or no deductible option according to benefit design chosen by group. Remove any Tiers that are not a part of the plan design.* ***[Tier-1]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] ***[Tier-2]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] ***[Tiers 1 and 2]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] ***[Tier-3]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] ***[Tier-4]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] ***[Tiers 3 and 4]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] ***[Tier-5]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.] ***[Tier-6]*** [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.]

Payment Term And Description	Amounts
	[Tiers 5 and 6] [No Annual Drug Deductible.] *Include when Annual Drug Deductible applies.* [$[XX – XX] per Subscriber.]
[Specialty Prescription Drug Product Annual Deductible]	
Option 1: Include the applicable paragraphs and corresponding deductible language if application of the Specialty Annual Deductible is determined based on Specialty Prescription Drug Product, per Specialty Drug Product, per Therapeutic Class and/or growth hormone therapy. *[1]Include if the Specialty Annual Deductible provision applies only to Tier-2, Tier-3, Tier-4, Tier-5 and/or Tier-6 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this rider.) [2]Include if the Specialty Annual Deductible applies only to Network Benefits. [3]Include if the Specialty Annual Deductible applies only to Non-Network Benefits. [4] Include if the Specialty Annual Deductible applies to both Network and Non-Network Benefits. [5]Include if the Specialty Annual Deductible applies to drugs from a Designated Pharmacy.* [The amount you pay for covered [[1][Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and] [Tier-6]] Specialty Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4] at a Network or non-Network Pharmacy] [or] [[5]a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.] *Option 2: Include the following paragraph and corresponding deductible language if application of the Specialty Annual Deductible is determined based on tier status.* *[1]Include the tiers that the Specialty Annual Deductible provision applies to: Tier-1, Tier-2, Tier-3, Tier-4, Tier-5*	*The options below correspond with Option 1.* *[1]Include if there is an annual deductible for all Specialty Prescription Drug Products. Include exception language when separate deductibles are included for growth hormone and/or Therapeutic Class. [2]Include if there is an annual deductible Per Specialty Prescription Drug Product. Include exception language when separate deductibles are included for growth hormone and/or Therapeutic Class. [3]Include if there is a separate annual deductible for Specialty Prescription Drug Products - Growth Hormone Therapy.* [[1]***Specialty Prescription Drug Product]*** *Include when Specialty Prescription Drug Product Deductible applies.* [$[XX – XX] per Subscriber for Specialty Prescription Drug Products.] [This does not include any deductible stated below.] [[2]***Specialty - Per Specialty Prescription Drug Product]*** *Include when Per Specialty Prescription Drug Product Deductible applies.* [$[XX – XX] per Specialty Prescription Drug Product per Subscriber.] [This does not include any deductible stated below.] [[3]***Specialty - Growth Hormone Therapy]*** *Include when Specialty - Growth Hormone Deductible applies.* [$[XX – XX] for Specialty Prescription Drug Products for growth hormone therapy per Subscriber.] *Include the paragraphs below if the Specialty Annual Deductible applies per Therapeutic Class and include the applicable deductible amounts or no annual deductible based on plan design.* [***Specialty - Per Therapeutic Class]*** [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class A.] *Include when Specialty - Per Therapeutic Class A Deductible applies.* [$[XX – XX] per Subscriber for Specialty Prescription Drug Products in Therapeutic Class A.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class B.] *Include when Specialty - Per Therapeutic Class B Deductible applies.*

Payment Term And Description	Amounts
and/or Tier-6 Specialty Prescription Drug Products. (Include commas and "ands" as applicable to the number of Tiers covered under this Rider.) [2]Include if the Specialty Annual Drug Deductible applies only to Network Benefits. [3]Include if the Specialty Annual Drug Deductible applies only to Non-Network Benefits. [4] Include if the Specialty Annual Drug Deductible applies to both Network and Non-Network Benefits. [5] Include if the Specialty Annual Drug Deductible applies to drugs from a Designated Pharmacy. [The amount you pay for covered [[1][Tier-1] [,] [Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and] [Tier-6]] Specialty Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4]at a Network or non-Network Pharmacy] [or] [[5] a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.] *Include when an Annual Drug Deductible applies.* [The Specialty Prescription Drug Product Annual Deductible is included in the overall Annual Drug Deductible stated above.]	[$[XX – XX] per Subscriber for Specialty Prescription Drug Products in Therapeutic Class B.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class C.] *Include when individual Specialty - Per Therapeutic Class C Deductible applies.* [$[XX – XX] per Subscriber for Specialty Prescription Drug Products in Therapeutic Class C.] *The options below correspond with Option 2.* *Included appropriate Tiers based on plan design. Insert deductible amounts according to benefit design chosen by group. Remove any Tiers that are not a part of the plan design.* *Insert deductible amounts according to benefit design chosen by group.* [***Tier-1]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when Tier-1 Deductible applies.* [$[XX – XX] per Subscriber.] [***Tier-2]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when Tier-2 Deductible applies.* [$[XX – XX] per Subscriber.] [***Tiers 1 and 2]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when Tiers-1 & 2 Deductible applies.* [$[XX – XX] per Subscriber.] [***Tier-3]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when Tier-3 Deductible applies.* [$[XX – XX] per Subscriber.] [***Tier-4]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when Tier-4 Deductible applies.* [$[XX – XX] per Subscriber.] [***Tiers 3 and 4]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when Tiers-3 & 4 Deductible applies.* [$[XX – XX] per Subscriber.]

Payment Term And Description	Amounts
	[***Tier-5]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when Tier-5 Deductible applies.* [$[XX – XX] per Subscriber.] [***Tier-6]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when Tier-6 Deductible applies.* [$[XX – XX] per Subscriber.] [***Tiers 5 and 6]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when Tier-5 & 6 Deductible applies.* [$[XX – XX] per Subscriber.]
[Out-of-Pocket Drug Maximum]	
Include text if Copayments and/or Coinsurance are limited by the Out-of-Pocket Drug Maximum. Select either separate statement for Network Benefits and Non-Network Benefits (and delete the combined choice) or select the combined option (and delete the separate Network/Non-Network choices). *[1]Include if OOPDM includes Copayments.[2]Include for plans with Copayment and Coinsurance options and the OOPDM does not include Copayments.* [The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [[1]Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the year. [[2]The Out-of-Pocket Drug Maximum does not include Copayments.]] *Include when there is a separate Specialty Prescription Drug Product OOPM.* [Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by the Out-of-	*Insert maximum amounts according to benefit design chosen by group.* *[1]Include if Copayments and Coinsurance are not subject to an Out-of-Pocket Drug Maximum.* *[2]Include if Copayments and/or Coinsurance are subject to an Out-of-Pocket Drug Maximum and the benefit design includes an Annual Drug Deductible.* *[3]If an Annual Drug Deductible applies, select the appropriate statement about whether or not the Annual Drug Deductible applies to the OOPDM.* [***Network]*** *Include when OOPDM applies* [$[XX – XX] per Subscriber.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] [***Non-Network]*** *Include when OOPDM applies.* [$[XX – XX] per Subscriber.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] [***Network and Non-Network]*** *Include when OOPDM applies.*

Payment Term And Description	Amounts
Pocket Drug Maximum.]	[$[XX – XX] per Subscriber.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.]
Include when there is a separate SOOPDM. **[Specialty Prescription Drug Product Out-of-Pocket Maximum]**	
Include text if Copayments and/or Coinsurance are limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum.[1]Include if SOOPM includes Copayments.[2]Include for plans with Copayment and Coinsurance options and the SOOPM does not include Copayments. [The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [[1]Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the year. [[2]The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]]	*Insert maximum amounts according to benefit design chosen by group.* *[1]Include when a separate Specialty Prescription Drug Product Out-of-Pocket Maximum applies to growth hormone therapy and/or per Therapeutic Class.* *[2]Include if Copayments and/or Coinsurance are subject to a Specialty Prescription Drug Product Out-of-Pocket Maximum and the benefit design includes a Specialty Prescription Drug Product Annual Deductible.* *[3]If a Specialty Prescription Drug Product Annual Deductible applies, select the appropriate statement about whether or not the Specialty Prescription Drug Product Annual Deductible applies to the Specialty Prescription Drug Product Out-of-Pocket Maximum.* *[4]Include if Copayments and Coinsurance are not subject to a Specialty Prescription Drug Product Out-of-Pocket Maximum.* *Include for groups that purchase Specialty pharmacy and an SOOPM applies separately to all Specialty Prescription Drug Products.* [***Specialty Prescription Drug Product]*** *Include when SOOPM applies.* [$[XX – XX] for Specialty Prescription Drug Products per Subscriber.] [[1]This does not include any maximum stated below.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] *Include for groups that purchase Specialty pharmacy and SOOPM applies per Specialty Prescription Drug Product.* [***Specialty - Per Specialty Prescription Drug Product]*** *Include when SOOPM per product applies.* [$[XX – XX] per Specialty Prescription Drug Product per Subscriber.] [[1]This does not include any maximum stated below.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product

Payment Term And Description	Amounts
	Annual Deductible.] *Include for group that purchase Specialty pharmacy and a separate SOOPM applies for growth hormone therapy products.* [***Specialty - Growth Hormone Therapy]*** *Include when individual SOOPM for Growth Hormone applies* [$[XX – XX] for Specialty Prescription Drug Products for growth hormone therapy per Subscriber.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.] *Include the paragraphs below if the Specialty Out-of-Pocket Maximum applies per Therapeutic Class and include the applicable SOOPM amount or no SOOPM based on plan design.* [***Specialty - per Therapeutic Class]*** *Include when individual SOOPM per Therapeutic Class A applies* [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class A per Subscriber.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class A are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.] *Include when SOOPM per Therapeutic Class B applies.* [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class B per Subscriber.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class B are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.] *Include when SOOPM per Therapeutic Class C applies.* [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class C per Subscriber.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class C are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.]
[Annual Maximum Drug Benefit]	

Payment Term And Description	Amounts
Include text if there is an Annual Maximum Drug Benefit. [The maximum amount we will pay for covered Prescription Drug Products during the year.]	*Choose separate maximum for Network and Non-Network Benefits or a combined maximum, depending on plan design.* *Insert maximum amounts according to benefit design chosen by group.* [***Network]*** [$[XX - XX] per Subscriber.] *Insert maximum amounts according to benefit design chosen by group.* [***Non-Network]*** [$[XX - XX] per Subscriber.] *Insert maximum amounts according to benefit design chosen by group.* [***Network and Non-Network]*** [$[XX - XX] per Subscriber.]
[Specialty Prescription Drug Product Annual Maximum Benefit]	
Include text if there is a Specialty Prescription Drug Product Annual Maximum Benefit. [The maximum amount we will pay for covered Specialty Prescription Drug Products during a year.] *Include if there is an overall Annual Maximum Drug Benefit in this Rider.* [The Specialty Prescription Drug Product Annual Maximum Benefit is included in the overall Annual Maximum Drug Benefit stated above.]	*Include for groups that purchase the Specialty Drug program with an Annual Maximum for Specialty Prescription Drug Products.* *Insert maximum amounts according to benefit design chosen by group.* *[1]Include when a separate annual maximum applies for growth hormone therapy and/or per Therapeutic Class.* [***Specialty Prescription Drug Product]*** [$[XX - XX] for Specialty Prescription Drug Products per Subscriber.] [[1]This does not include any maximum stated below.] *Include for groups that purchase the specialty program with an Annual Maximum per Specialty Drug.* *Insert maximum amounts according to benefit design chosen by group.* *[1]Include when a separate annual maximum applies for growth hormone therapy and/or per Therapeutic Class.* [***Specialty - Per Specialty Prescription Drug Product]*** [$[XX - XX] per Specialty Prescription Drug Product per Subscriber.] [[1]This does not include any maximum stated below.] *Include for groups that purchase the specialty program with an Annual Maximum for Growth Hormone Therapy.* *Insert maximum amounts according to benefit design chosen by group.* [***Specialty - Growth Hormone Therapy]*** [$[XX - XX] for Specialty Prescription Drug Products for growth hormone therapy per Subscriber.] *Include the paragraphs below if the Specialty Annual Maximum applies per Therapeutic Class and include the applicable number of classes.* [***Specialty - Per Therapeutic Class]***

Payment Term And Description	Amounts
	[$[XX - XX] per Therapeutic Class A for Specialty Prescription Drug Products per Subscriber.] [$[XX - XX] per Therapeutic Class B for Specialty Prescription Drug Products per Subscriber.] [$[XX - XX] per Therapeutic Class C for Specialty Prescription Drug Products per Subscriber.]
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Cost. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate. ***Copayment and Coinsurance*** Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product. *Include when programs are available for enhanced benefits.* [Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable notification, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. *Include for groups that purchase the mail order pharmacy benefit.* [For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Prescription Drug Cost for that Prescription Drug Product.] See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.

Payment Term And Description	Amounts
such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Include when plan includes Specialty Drug Program. **[Specialty Prescription Drug Products]**	
[The following supply limits apply. • As written by the provider, up to a consecutive [31] [60]-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive [31]-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[1]Include commas and "or" as required to accommodate plan design. [2] Include when plan design includes mail order pharmacy benefits. [3]Include when plan design includes Designated Pharmacy.* Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [[1],] [[1]or] a non-Network Pharmacy [[1],] [[1]or] [[2]a mail order Network Pharmacy] [[1]or] [[3]a Designated Pharmacy].]	*Benefits are provided for either a 2-Tier, 3-Tier, 4-Tier, 5-Tier, or 6-Tier Benefit. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more. [3] Delete comma and include "or" when benefit design is 4 Tier. Include comma and delete "or" when benefit design is 5 Tier or more. [4] Delete comma and include "or" when benefit design is 5 Tier. Include comma and delete "or" when benefit design is 6 Tier. [5]Include when benefit design is 6 Tier.* *[7]Always include introductory paragraph and Copayment and Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose [6]"No Copayment."* [[7]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4] [[4],] [[4] or] [Tier-5] [[5], or Tier-6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] ***[Network Pharmacy]*** *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after

Description and Supply Limits	Benefit (The Amount We Pay)
	you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you

Description and Supply Limits	Benefit (The Amount We Pay)
	pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 3 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below if the benefit design is 4 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for

Description and Supply Limits	Benefit (The Amount We Pay)
	specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below if the benefit design is 5 Tier or more. *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-5 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a

Description and Supply Limits	Benefit (The Amount We Pay)
	Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-6 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[6]No Copayment] ***[Non-Network Pharmacy]*** *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per*

Description and Supply Limits	Benefit (The Amount We Pay)
	Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-2 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of

Description and Supply Limits	Benefit (The Amount We Pay)
	$[___]] per Prescription Order or Refill [2, except that we pay [3[___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [1after you pay a Copayment of $[___]]] [4and we pay] [5[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [1after you pay a Copayment of $[___]]] [6,] [7and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [1after you pay a Copayment of $[___]]] [8, and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [1after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [9[However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [1after you pay a Copayment of $[___]] per Prescription Order or Refill. [2[However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [1after you pay a Copayment of $[___]] per Prescription Order or Refill [2, except that we pay [3[___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [1after you pay a Copayment of $[___]]] [4and we pay] [5[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [1after you pay a Copayment of $[___]]] [6,] [7and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [1after you pay a Copayment of $[___]]] [8, and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [1after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [9[However,] [you

Description and Supply Limits	Benefit (The Amount We Pay)
	will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]*Include when a Copayment is required.* [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-4 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below if the benefit design is 5 Tier or more. [1]*Include when a Copayment is required.* [2]*Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class.* [3]*Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy.* [4]*Include when growth hormone and therapeutic Copayments and/or Coinsurance are included.* [5]*Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C).* [6]*Include "," when A, B, and C apply.* [7]*Include "and" when only A&B apply.* [8]*Include when C applies.* [9]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-5 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]*Include when a Copayment is required.* [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-5 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement

Description and Supply Limits	Benefit (The Amount We Pay)
	Rate [1after you pay a Copayment of $[___]] per Prescription Order or Refill. [2[However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [1after you pay a Copayment of $[___]] per Prescription Order or Refill [2, except that we pay [3[___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [1after you pay a Copayment of $[___]]] [4and we pay] [5[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [1after you pay a Copayment of $[___]]] [6,] [7and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [1after you pay a Copayment of $[___]]] [8, and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [1after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [9[However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [1after you pay a Copayment of $[___]] per Prescription Order or Refill. [2[However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [6No Copayment] *Include when Closed Benefit Plan applies* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier or more. [2] Delete comma and include "or" when Closed benefit is 3 Tier. Include comma and delete "or" when*

Description and Supply Limits	Benefit (The Amount We Pay)
	closed benefit plan is 4 Tier or more. [3] Delete comma and include "or" when the closed benefit plan is 4 Tier. Include comma and delete "or" when closed benefit plan is 5 Tier. [4] Include when closed benefit design is 5 Tier. [Specialty Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3]or] [Tier-4] [[4]or Tier-5] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • If the Network Pharmacy agrees to provide the same services or products for the same terms as the Mail Order Network Pharmacy, you may obtain up to a consecutive 90-day supply of a Prescription Drug Product. *Contraceptives are mandated in AR, except for religious group employers or for when this mandate is not included in accordance with AR statute 23-79-801 et seq.* • [A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.] When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[1]Include when plan design includes Preferred Retail Network Pharmacy and Copayments and/or Coinsurance are reduced for Prescription Drug Products obtained at a Preferred pharmacy. Select Copayment and Coinsurance*	*Benefits are provided for either 2-Tier, 3-Tier, 4-Tier, 5-Tier, or 6-Tier Benefit. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more. [3] Delete comma and include "or" when benefit design is 4 Tier. Include comma and delete "or" when benefit design is 5 Tier or more. [4] Delete comma and include "or" when benefit design is 5 Tier. Include comma and delete "or" when benefit design is 6 Tier. [5]Include when benefit design is 6 Tier.* *[7]Always include introductory paragraph and Copayment and Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose [6]"No Copayment".* [[7]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4] [[4],] [[4] or] [Tier-5] [[5], or Tier-6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per

Description and Supply Limits	Benefit (The Amount We Pay)
options depending on plan design. *[2]Include when plan design includes Preferred Retail Network Pharmacy and Copayments and/or Coinsurance are increased when Prescription Drug Products are obtained at a non-Preferred pharmacy. Select Copayment and Coinsurance options depending on plan design.* [[1]If you use a Preferred Retail Network Pharmacy, your Copayment will be reduced by [$XX] per Prescription Order or Refill.] [[1]If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by [__]% of the Prescription Drug Cost per Prescription Order or Refill.] [[2]If you use a Non-Preferred Retail Network Pharmacy, your Copayment will be increased by [$XX] per Prescription Order or Refill.] [[2]If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by [__]% of the Prescription Drug Cost per Prescription Order or Refill.]	Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include*

Description and Supply Limits	Benefit (The Amount We Pay)
	when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment*

Description and Supply Limits	Benefit (The Amount We Pay)
	is required. [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 5 Tier or more.* [1]*Include when a Copayment is required.* [2]*Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes.* [3]*Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C).* [4]*Include "," when A, B, and C apply.* [5]*Include "and" when only A&B apply.* [6]*Include when C applies.* [7]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications.* [1]*Include when a Copayment is required.* [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* [1]*Include when a Copayment is required.* [2]*Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes.* [3]*Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C).* [4]*Include "," when A, B, and C apply.* [5]*Include "and" when only A&B apply.* [6]*Include when C applies.* [7]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-6 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[6]No Copayment] *Include when plan design includes some level of closed benefit plan.* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier or more. [2] Delete comma and include "or" when Closed benefit is 3 Tier. Include comma and delete "or" when closed benefit plan is 4 Tier or more. [3] Delete comma and include "or" when the closed benefit plan is 4 Tier. Include comma and delete "or" when closed benefit plan is 5 Tier. [4] Include when closed benefit design is 5 Tier.* [Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3]or] [Tier-4] [[4]or Tier-5] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Non-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. *Contraceptives are mandated in AR,*	*Benefits are provided for either a 2-Tier, 3-Tier, 4-Tier, 5-Tier, or 6-Tier Benefit. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more. [3] Delete comma and include "or" when benefit design is 4 Tier. Include comma and delete "or" when benefit design is 5 Tier or more. [4] Delete comma and include "or" when benefit design is 5 Tier. Include comma and delete*

Description and Supply Limits	Benefit (The Amount We Pay)
except for religious group employers or for when this mandate is not included in accordance with AR statute 23-79-801 et seq. • [A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.] When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	*"or" when benefit design is 6 Tier. [5]Include when benefit design is 6 Tier.* *[7]Always include introductory paragraph and Copayment and Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose. [6]"No Copayment."* [[7]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4] [[4],] [[4] or] [Tier-5] [[5], or Tier-6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include ","*

Description and Supply Limits	Benefit (The Amount We Pay)
	when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-2 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per

Description and Supply Limits	Benefit (The Amount We Pay)
	Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 5 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic*

Description and Supply Limits	Benefit (The Amount We Pay)
	Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-5 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will

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	not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications.* [1]*Include when a Copayment is required.* [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[6]No Copayment] *Include when plan includes some level of closed benefit plan* [1]*Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier or more.* [2] *Delete comma and include "or" when Closed benefit is 3 Tier. Include comma and delete "or" when closed benefit plan is 4 Tier or more.* [3] *Delete comma and include "or" when the closed benefit plan is 4 Tier. Include comma and delete "or" when closed benefit plan is 5 Tier.* [4] *Include when closed benefit design is 5 Tier.* [Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3]or] [Tier-4] [[4] or Tier-5] of the Prescription Drug List are not covered.]
Include for groups that purchase the mail order benefit. **[Prescription Drug Products from a Mail Order Network Pharmacy]**	
[The following supply limits apply: [1]*Include if benefit plan design includes specialty drug program.* [2]*Include if benefit plan design includes the List of Preventive Medications.* • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [[1]These supply limits do not apply to Specialty Prescription Drug Products[[2], including Specialty Prescription Drug Products on the List of Preventive Medications].	*Benefits are provided for either a 2-Tier, 3-Tier, 4-Tier, 5-Tier, or 6-Tier Benefit.* [1]*Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more.* [2] *Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more.* [3] *Delete comma and include "or" when benefit design is 4 Tier. Include comma and delete "or" when benefit design is 5 Tier or more.* [4] *Delete comma and include "or" when benefit design is 5 Tier. Include comma and delete "or" when benefit design is 6 Tier.* [5]*Include when benefit design is 6 Tier.* [7]*Always include introductory paragraph and Copayment and/or Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose* [6]*"No Copayment."* [[8]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the

Description and Supply Limits	Benefit (The Amount We Pay)
Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*.] *Include if coverage is initially required at a retail pharmacy prior to using mail order.* [You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refills through a retail pharmacy prior to using a mail order Network Pharmacy.] *Include the following paragraph only when mail order Copayments and/or Coinsurance in the right hand column are charged for the full 90 day supply. Delete if Copayments and/or Coinsurance are tied to the 31, 60 and 90 day supply.* [[1]To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.]]	Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4] [[4],] [[4] or] [Tier-5] [[5], or Tier-6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *There are two Copayment and/or Coinsurance options. The first is to tie the number of days' supply to the Copayment and/or Coinsurance level at 31 days, 60 days and 90 days. The second option is to apply a Copayment and/or Coinsurance, calculated only at the 90-day level, for any number of days' supply of mail order drugs.* *Include text when Copayments and/or Coinsurance are tied to a number-of-days' supply. Delete if a single Copayment and/or Coinsurance applies to any supply of mail order drugs.* [For up to a 31-day supply, we pay:] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include*

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	when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment*

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	is required. [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 4 Tier or more.* [1]*Include when a Copayment is required.* [2]*Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes.* [3]*Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C).* [4]*Include "," when A, B, and C apply.* [5]*Include "and" when only A&B apply.* [6]*Include when C applies.* [7]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications.* [1]*Include when a Copayment is required.* [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 5 Tier or more.* [1]*Include when a Copayment is required.* [2]*Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes.* [3]*Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C).* [4]*Include "," when A, B, and C apply.* [5]*Include "and" when only A&B apply.* [6]*Include when C applies.* [7]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-5 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include following paragraphs (describing a 60-day supply limit) only when Copayments and/or Coinsurance are tied to days' supply. Delete if a single Copayment and/or Coinsurance applies to any supply of mail order drugs.* [For up to a 60-day supply, we pay:] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is*

Description and Supply Limits	Benefit (The Amount We Pay)
	limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited*

Description and Supply Limits	Benefit (The Amount We Pay)
	by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 5 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-5 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include following paragraphs describing a 90-day supply limit only when Copayments and/or Coinsurance are tied to days' supply. Delete if a single Copayment and/or Coinsurance applies to any supply of mail order drugs.* [For up to a 90-day supply, we pay:] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is*

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	limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited*

Description and Supply Limits	Benefit (The Amount We Pay)
	by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 5 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-5 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[6]No Copayment] *Include when plan includes some level of closed benefit plan* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier or more. [2] Delete comma and include "or" when Closed benefit is 3 Tier. Include comma and delete "or" when closed benefit plan is 4 Tier or more. [3] Delete comma and include "or" when the closed benefit plan is 4 Tier. Include comma and delete "or" when closed benefit plan is 5 Tier. [4] Include when closed benefit design is 5 Tier.* [Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3]or] [Tier-4] [[4] or Tier-5] of the Prescription Drug List are not covered.]

Vision Care Services Rider

[United HealthCare Insurance Company]

This Rider to the Policy provides Benefits for Vision Care Services as described below.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Rider in *Section 4: Defined Terms.*

When we use the words "you" and "your," to describe the rights to Benefits under the Policy, we are referring to people who are Subscribers, as that term is defined in the *Certificate* in *Section 9: Defined Terms*. When we use the words "you" and "your" to describe responsibilities under the Policy, we are also referring to the parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber.

Include only one of the COB options listed below.

Include if COB does not apply to Vision benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Vision Care Services covered through this Rider. Vision Care Services Benefits will not be coordinated with those of any other health coverage plan.]

Include if COB applies to Vision benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Vision Care Services Benefits covered through this Rider. Benefits for Vision Care will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

Include if Subrogation does not apply to Vision benefits. Delete if subrogation applies.

[NOTE: The Subrogation and Reimbursement provision in the *Certificate* in *Section 8: General Legal Provisions* does not apply to Vision Care Services covered through this Rider.]

Section 1: Benefits for Vision Care Services

Benefits are available for Vision Care Services from a Network or non-Network Vision Care Provider. To find a Network Vision Care Provider, you may call [the provider locator service at 1-800-839-3242]. You may also access a listing of Network Vision Care Providers on the Internet at [www.uhcspecialtybenefits.com].

When you obtain Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim* and in this Rider under *Section 3: Claims*. Reimbursement will be limited to the amounts stated below.

[1]Include when Copayments apply to any network benefit.

[[1]When obtaining these Vision Care Services from a Network Vision Care Provider, you will be required to pay any Copayments at the time of service.]

Include when Copayments apply to any network benefit. [1]Select applies or does not apply per benefit design.

[Out-of-Pocket Maximum - any amount you pay in Copayments for Vision Care Services under this Rider [[1]applies] [[1]does not apply] to the Out-of-Pocket Maximum stated in the Schedule of Benefits.]

Benefit Description

Frequency of Service Limits

[1]Include when Copayments apply to any network benefit.

~~2Include when Frequency of Service limits increase apply.~~

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits [[1]and Copayments] stated under each Vision Care Service.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

Delete bulleted services that do not apply to plan design.

- [A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.]
- [Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).]
- [Cover test at 20 feet and 16 inches (checks eye alignment).]
- [Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.]
- [Pupil responses (neurological integrity).]
- [External exam.]
- [Internal exam.]
- [Retinoscopy (when applicable) – objective refraction to determine lens power of corrective subjective refraction – to determine lens power of corrective lenses.]
- [Phorometry/Binocular testing – far and near: how well eyes work as a team.]

- [Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).]
- [Tonometry, when indicated: test pressure in eye (glaucoma check).]
- [Ophthalmoscopic examination of the internal eye.]
- [Confrontation visual fields.]
- [Biomicroscopy.]
- [Color vision testing.]
- [Diagnosis/prognosis.]
- [Specific recommendations.]

Post examination procedures will be performed only when materials are required.

Under Network and Non-Network Benefits, include applicable benefit level per plan design.

[1]Include when Copayment applies.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination	Once every [12] months.	100% of Eligible Expenses [[1]after a Copayment of $[10]].	100% of the billed charge to a maximum of $[40].

Include Paragraphs and Table below only when plan includes benefits for eyeglass lenses.

[Eyeglass Lenses]

[Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.]

[You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.]

[If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Network Vision Care Provider, only one Copayment will apply to those *Eyeglass Lenses* and *Eyeglass Fra*mes together.]

Under Network and Non-Network Benefits, include applicable benefit level per plan design.

[1]Include when Copayment applies.

[Vision Care Service]	[Frequency of Service]	[Network Benefit]	[Non-Network Benefit]
[Eyeglass Lenses]	[Once every [12] months.]		
• *[Single Vision]*		[100% of Eligible Expenses [[1]after a Copayment of $[25]].]	[100% of the billed charge to a maximum of $[40].]
• *[Bifocal]*		[100% of Eligible Expenses [[1]after a Copayment of $[25]].]	[100% of the billed charge to a maximum of $[60].]

• *[Trifocal]*		[100% of Eligible Expenses [1after a Copayment of $[25]].]	[100% of the billed charge to a maximum of $[80].]
• *[Lenticular]*		[100% of Eligible Expenses [1after a Copayment of $[25]].]	[100% of the billed charge to a maximum of $[80].]

[Optional Lens Extras]

[Eyeglass Lenses. The following Optional Lens Extras are covered in full:

- [Scratch-resistant coating.]
- [Polycarbonate lenses.]]

Include Paragraphs and Table below only when plan includes benefits for eyeglass frames.

[Eyeglass Frames]

[A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.]

[You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.]

[If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Network Vision Care Provider, only one Copayment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.]

Under Network and Non-Network Benefits, include applicable benefit level per plan design.

[1]Include when Copayment applies.

[Vision Care Service]	[Frequency of Service	[Network Benefit]	[Non-Network Benefit]
[Eyeglass Frames]	[Once every [12] months.]		
• *[Covered Eyeglass Frame Selection]*		[100% of Eligible Expenses [1after a Copayment of $[25]] [from the Covered Eyeglass Frames Selection].]	[100% of the billed charge to a maximum of $[45].]
• *[Non-Selection Eyeglass Frames[- Retail Provider]]*		[100% of the billed charge to a maximum of $[130].]	[100% of the billed charge to a maximum of $[45].]
• *[Non-Selection Eyeglass Frames - Private Practice Provider]*		[100% of the wholesale cost to a maximum of $[45].]	[100% of the billed charge to a maximum of $[45].]

Include Paragraphs and Table below only when plan includes benefits for contact lenses.

[Contact Lenses]

[Lenses worn on the surface of the eye to correct visual acuity limitations.]

Include when supported by plan design.

[1]Include number of boxes per plan design.

[Benefits include the fitting/evaluation fees, contacts, and up to two follow-up visits.]

[You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.]

Include Paragraphs and Table below only when plan includes benefits for necessary contact lenses.

[Necessary Contact Lenses]

[Benefits are available when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:]

Include applicable condition by plan design.

- [Keratoconus or irregular astigmatism.]
- [Anisometropia of 3.50 diopters or more.]
- [Post-cataract surgery without intraocular lens.]
- [Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.]

Under Network and Non-Network Benefits, include applicable benefit level per plan design.

[1]Include when Copayment applies.

[Vision Care Service]	**[Frequency of Service]**	**[Network Benefit]**	**[Non-Network Benefit]**
[Contact Lenses]	[Once every [12] months.]		
• *[Covered Contact Lens Selection]*		[100% of Eligible Expenses [[1]after a Copayment of $[25]].]	[100% of the billed charge to a maximum of $[105].]
• *[Non-Selection Contact Lenses]*		[100% of Eligible Expenses to a maximum of $[105].]	[100% of the billed charge to a maximum of $[105].]
• *[Necessary Contact Lenses]*		[100% of Eligible Expenses [[1]after a Copayment of $[25]].]	[100% of the billed charge to a maximum of $[210].]

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider. In addition, the following exclusions apply:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the *Certificate*.

Include if vision hardware is not covered.

[2. Eyeglasses (including lenses and frames) and contact lenses of any kind.]

Delete if hardware is covered and non-prescription items are covered.

[2.] [Non-prescription items (e.g. Plano lenses).]

Delete if benefits are available for replacement lenses/frames.

[3.] [Replacement or repair of lenses and/or frames that have been lost or broken.]

Delete if benefits are available for optional lens extras.

[4.] [Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services*.]

Delete if missed appointment charges are not excluded.

[5.] [Missed appointment charges.]

Delete if benefits are available for sales tax on vision care services.

[6.] [Applicable sales tax charged on Vision Care Services.]

Section 3: Claims

When obtaining Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claims timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Vision Care Services

[1]*Include if a claim form is required.*

To file a claim for reimbursement for Vision Care Services rendered by a non-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Network Vision Care Provider or a non-Network Vision Care Provider), you must provide all of the following information [[1]on a claim form acceptable to us]:

1. Your itemized receipts.
2. Subscriber's name.
3. Subscriber's identification number.
4. Subscriber's date of birth.

Submit the above information to us:

By mail:

[Claims Department

P.O. Box 30978

Salt Lake City, UT 84130]

By facsimile (fax):

[248-733-6060]

Section 4: Defined Terms

Include Definitions below only when plan includes benefits for materials.

[Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.]

[Covered Eyeglass Frames Selection - a selection of available eyeglass frames that may be obtained from a Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.]

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this Rider in *Section 1: Benefits for Vision Care Services.*

Dental Services Rider

[United HealthCare Insurance Company]

This Rider to the Policy provides Benefits for Covered Dental Services as described below.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Rider in *Section 5: Defined Terms.*

When we use the words "you" and "your," to describe the rights to Benefits under the Policy, we are referring to people who are Subscribers, as that term is defined in the *Certificate* in *Section 9: Defined Terms*. When we use the words "you" and "your" to describe responsibilities under the Policy, we are also referring to the parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber.

Include only one of the COB options listed below.

Include if COB does not apply to Dental benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Covered Dental Services under this Rider. Benefits for Dental Services will not be coordinated with those of any other health coverage plan.]

Include if COB applies to Dental benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Covered Dental Services Benefits under this Rider. Benefits for Dental Services will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

Section 1: Accessing Dental Services

Network and Non-Network Benefits

Network Benefits - these Benefits apply when you choose to obtain Covered Dental Services from a Network Dentist. You generally are required to pay less to the provider than you would pay for services from a non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dentist an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, you must obtain all Covered Dental Services directly from or through a Network Dentist.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to Network Dentists. If you use a provider that is not a participating provider, you will be required to pay the entire bill for the services you received, after which you must file a claim with us to be reimbursed for Eligible Dental Expenses.

[1]Change reference to customer service as needed

We will make available to you a *Directory of Network Dentists*. You can also call [*[1]Customer Service*] to determine which providers participate in the Network. The telephone number for [*[1]Customer Service*] is on your ID card.

Non-Network Benefits - These Benefits apply when you decide to obtain Covered Dental Services from non-Network Dentists. You generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary fee for similarly situated Network Dentists for each Covered Dental Service. The actual charge made by a non-Network Dentist for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay a non-Network Dentist an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from non-Network Dentists, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in this Rider if such Dental Services are Necessary and are provided by or under the direction of a Dentist or other provider.

Benefits are available only for Necessary Dental Services. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service under this Rider.

Include when pre-treatment estimate applies. [1]Adjust amount as needed. [2]Leave bracketed text in unless determined to remove.

[Pre-Treatment Estimate]

[If the charge for a Dental Service is expected to exceed [[1]$200] or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dentist should send a notice to us, via claim form, within 20 days of the exam. [[2]If requested, the Dentist must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.]]

[We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dentist and will be

subject to all terms, conditions and provisions of the Policy. [[2]Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.]]

[1]Use bracketed sentence if day limit applies. [2]Modify number of days the estimate is valid as needed. [3]Modify number of days when treatment must be received as needed.

[A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment. [[1]The pre-treatment estimate is valid for [[2]90] days from the date we provide it to the Dentist. If you will not receive the services within the [[3]90] days, you or the Dentist must request another pre-treatment estimate from us.]]

Include if Plan requires Pre-Authorization. [1]Select from one of these options. [2]Modify amount. [3]List the specific dental services that preauthorization applies to. [4]Include if applicable. [5]Include if applicable.

[Pre-Authorization]

[Pre-authorization is required [[1]for all Dental Services] [[1]for Dental Services expected to cost over [[2]$200]] [[1]for the following services: [[3]list specific dental services that pre-authorization would apply to]]. Speak to your Dentist about obtaining a pre-authorization before Dental Services are rendered. [[4]If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.]]

[[5]If a treatment plan is not submitted, you will be responsible for payment of any dental treatment not approved by us. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.]

Section 2: Benefits for Covered Dental Services

Benefits are provided for the Dental Services stated in this Section when such services are:

A. Necessary.

B. Provided by or under the direction of a Dentist.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Exclusions* of this Rider.

Benefits for Covered Dental Services are subject to satisfaction of the Dental Services Deductible and the Maximum Dental Benefit as stated below.

Network Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Non-Network Benefits:

Benefits for Eligible Dental Expenses from non-Network providers are determined as a percentage of the Usual and Customary fee. You must also pay the amount by which the non-Network provider's billed charge exceeds the Usual and Customary fee.

[1]Insert the deductible amount. [2]Select either Policy or calendar year.

Dental Services Deductible

The Dental Services Deductible is [[1] $0 -$3,000] per Subscriber for Network Benefits and [[1] $0 - $3,000] per Subscriber for Non-Network Benefits per [[2]Policy] [[2]calendar] year.

The Dental Services Deductible does not apply to *Diagnostic Services* and/or *Preventive Services*.

[1]Insert the maximum dental benefit amount. [2]Select either Policy or calendar year.

Maximum Dental Benefit

The Maximum Dental Benefit is [[1]$500 - $5,000] per Subscriber for any combination of Network Benefits and Non-Network Benefits per [[2]Policy] [[2]calendar] year.

Benefit Description

Benefit Description and Limitations	Network Benefits **Network Benefits are shown as a percentage of Eligible Dental Expenses, after the Dental Services Deductible is satisfied.**	Non-Network Benefits **Non-Network Benefits are shown as a percentage of Eligible Dental Expenses after the Dental Services Deductible is satisfied.**
Diagnostic Services (Not subject to payment of the Dental Services Deductible.)		
Intraoral Bitewing Radiographs Limited to 1 series of films per consecutive 12 months.	[80 – 100]%	[80 – 100]%
Panorex Radiographs Limited to 1 time per consecutive 36 months.	[80 – 100]%	[80 – 100]%
Periodic Oral Evaluation Limited to 2 times per consecutive 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	[80 – 100]%	[80 – 100]%
Preventive Services (Not subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) Limited to 2 times per consecutive 12 months.	[80 – 100]%	[80 – 100]%
Fluoride Treatments Limited to Subscribers under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.	[80 – 100]%	[80 – 100]%
Sealants Limited to Subscribers under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	[80 – 100]%	[80 – 100]%
Space Maintainers (Subject to payment of the Dental Services Deductible.)		
Space Maintainers Limited to Subscribers under the age of 16 years, once per lifetime. Includes all adjustment within 6 months of installation.	[50 - 80]%	[50 - 80]%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery (Subject to payment of the		

Benefit Description and Limitations	Network Benefits Network Benefits are shown as a percentage of Eligible Dental Expenses, after the Dental Services Deductible is satisfied.	Non-Network Benefits Non-Network Benefits are shown as a percentage of Eligible Dental Expenses after the Dental Services Deductible is satisfied.
Dental Services Deductible.)		
Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	[50 - 80]%	[50 - 80]%
Composite Resin Restorations (Fillings) For anterior teeth only.	[50 - 80]%	[50 - 80]%
Root Canal Therapy Limited to 1 time per site per lifetime.	[50 - 80]%	[50 - 80]%
Periodontal Surgery Limited 1 per site per consecutive 36 months.	[50 - 80]%	[50 - 80]%
Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months.	[50 - 80]%	[50 - 80]%
Periodontal Maintenance Limited to two times per consecutive 12 months period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.	[50 - 80]%	[50 - 80]%
Simple Extractions	[50 - 80]%	[50 - 80]%
Surgical Extraction, including Impacted Wisdom Teeth	[50 - 80]%	[50 - 80]%
Adjunctive Services (Subject to payment of the Dental Services Deductible.)		
General Services (including Emergency Treatment) Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary.	[50 - 80]%	[50 - 80]%
Major Restorative Services (Subject to payment of the Dental Services Deductible.) [Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays		

Benefit Description and Limitations	Network Benefits **Network Benefits are shown as a percentage of Eligible Dental Expenses, after the Dental Services Deductible is satisfied.**	Non-Network Benefits **Non-Network Benefits are shown as a percentage of Eligible Dental Expenses after the Dental Services Deductible is satisfied.**
previously submitted for payment under the Policy is limited to [1] [time][s] per [consecutive] [[36 -120] months] [[calendar] [Policy] year] from initial or supplemental placement.]		
Inlays/Onlays/Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.	[50 - 80]%	[50 - 80]%
Fixed Prosthetics (Subject to payment of the Dental Services Deductible.) [Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to [1] [time][s] per [consecutive] [[36 -120] months] [[calendar] [Policy] year] from initial or supplemental placement.]		
Fixed Prosthetics Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. (Alternate Benefits for a partial denture may be applied.)	[50 - 80]%	[50 - 80]%

Section 3: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider. In addition, the following exclusions apply:

Except as may be specifically provided in *Section 2: Benefits for Covered Dental Services*, Benefits are not provided under this Dental Services Rider for the following:

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Subscriber becoming enrolled for coverage provided through this Rider to the Policy.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant

prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

[1]Modify number of months as applicable.

19. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been enrolled for coverage provided through this Rider to the Policy for [[1]36] continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this [[1]36 month] period, the plan is responsible only for the procedures associated with the addition.

[1]Modify number of months as applicable.

20. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been enrolled for coverage provided through this Rider to the Policy for [[1]36] continuous months.

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

25. Orthodontic services.

26. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in *Section 2: Benefits for Covered Dental Services*.

Section 4: Claims

When obtaining Dental Services from a non-Network provider, you will be required to pay all billed charges directly to your provider. You may then seek reimbursement from us. Information about claims timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* applies to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Subscriber's name and address.
- Subscriber's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dentist including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call us at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 days of your request, send in the proof of loss with the information stated above.

Section 5: Defined Terms

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this Rider.

Dental Service or Dental Procedures - dental care or treatment provided by a Dentist to a Subscriber while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

[1]Select either Policy or calendar year.

Dental Services Deductible - the amount a Subscriber must pay for Covered Dental Services in a [[1]Policy] [[1]calendar] year before we will begin paying for Network or Non-Network Benefits in that year.

Dentist - any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

A. For Network Benefits, when Covered Dental Services are received from Network Dentists, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.

B. For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dentists, Eligible Dental Expenses are the Usual and Customary fees, as defined below.

[1]Select either Policy or calendar year.

Maximum Dental Benefit - the maximum amount paid per Subscriber for Covered Dental Services during a [[1]Policy] [[1]calendar] year.

Necessary - Dental Services and supplies under this Rider which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Subscriber.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Subscriber or his or her Dentist.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Rider. The definition of Necessary used in this Rider relates only to Benefits under this Rider and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Usual and Customary - Usual and Customary fees are calculated by us based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (publication of the *American Dental Association*).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that we accept.

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
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Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification — Approved-Closed — 03/25/2009

Comments:

Attachment:

Readability Certification - INS.pdf

Review Status:

Bypassed -Name: Application — Approved-Closed — 03/25/2009

Bypass Reason: The applications to be used with the forms of this submission are included in the submission.

Comments:

Review Status:

Satisfied -Name: Cover Letter — Approved-Closed — 03/25/2009

Comments:

Attachment:

CSIS Submission Cover Letter.pdf

Review Status:

Satisfied -Name: Compliance Certification — Approved-Closed — 03/25/2009

Comments:

Attachment:

Certificate of Compliance - CSIS 3-6-09.pdf

United Healthcare Insurance Company
NAIC #79413

CERTIFICATION OF READABILITY

This is to certify that the accompanying form(s) comply (complies) with your state's readability requirements:

A. Option Selected

The form(s) is (are) scored separately for the Flesch reading ease test (except forms entitled by law to be exempt from the requirements of such law). Score(s) for the (each) form(s) is (are) indicated below (in the attached listing).

Form	Flesch Score
POL-CSIC.I.07.AR, et al. (Please see attached Forms Listing which contains the Flesch Score for each submitted form.	

B. Test Option Selected

Test was applied to each entire policy form.

C. Standards for Certification

A checked block indicates the standard has been achieved.

X 1. The form text achieves a minimum score of **40** on the Flesch reading ease test in accordance with the option chosen in Section A above.

X 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

X 3. The layout and spacing of the policy form(s) separate the paragraphs from each other and from the border of the paper.

X 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

X 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the form(s).

Forrest G. Burke

Forrest G. Burke
Secretary

Date: March 6, 2009

Forms Listing

Child Support Insurance Solution

United HealthCare Insurance Company

Form Number	Description/Title of Forms	Flesch or Readability Score
	Master Policy	
POL-CSIS.I.07.AR	Group Policy	48.8
PCOV-CSIS.I.07.AR	Group Policy Cover Page	68.6
EXB2NTC-CSIS.I.07.AR	Notice of Change to Exhibit 2	48.8
POLAMD-CSIS.I.AR	Amendment to Group Policy	46.5
EXB2NTCADD-CSIS.I.07.AR	Notice of Additional Exhibit 2	48.8
MAND-OFFERS.CSIS.I.08.AR	Arkansas State Mandated Offers Selection Form	40.3
MCS.ER.08.AR 03/08	Insured Group Application	40.5
MCS.EE.08.AR 01/09	Child Enrollment Application	46.5
	Member Certificate of Coverage **Child Support Insurance Solution - HealthBright Choice Plus**	
COC-CSISCP.CER.I.07.AR	Certificate of Coverage	70.7
COC-CSISCP.INT.I.07.AR	Introduction to Your Certificate	61.0
COC-CSISCP.YRP.I.07.AR	Your Responsibilities	56.2
COC-CSISCP.ORP.I.07.AR	Our Responsibilities	50.7
COC-CSISCP.TOC.I.07.AR	Table of Contents	69.3
COC-CSISCP.CHS.I.07.AR	Section 1: Covered Health Services	45.4
COC-CSISCP.EXC.I.07.AR	Section 2: Exclusions and Limitations	43.1
COC-CSISCP.BGN.I.07.AR	Section 3: When Coverage Begins	65.3
COC-CSISCP.END.I.07.AR	Section 4: When Coverage Ends	52.2
COC-CSISCP.CLM.I.07.AR	Section 5: How to File a Claim	64.9
COC-CSISCP.CPL.I.07.AR	Section 6: Questions, Complaints and Appeals	41.1
COC-CSISCP.COB.I.07.AR	Section 7: Coordination of Benefits	46.3

Form Number	Description/Title of Forms	Flesch or Readability Score
COC-CSISCP.LGL.I.07.AR	Section 8: General Legal Provisions	48.5
COC-CSISCP.DEF.I.07.AR	Section 9: Defined Terms	48.2
CCOV-CSISCP.I.07.AR	Certificate of Coverage - Cover Page - Choice Plus	68.6
	Member Certificate of Coverage **Child Support Insurance Solution - HealthBright Basics**	
COC-CSISB.CER.I.07.AR	Certificate of Coverage	70.7
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CCOV-CSISB.I.07.AR	Certificate of Coverage - Cover Page - Basics	68.6
	Schedules of Benefits	
SBN.CSISCP.I.07.AR	Schedule of Benefits for HealthBright Choice Plus	49.8
SBN.CSISB.I.07.AR	Schedule of Benefits for HealthBright Basics	50.9
	Optional Riders	
RDR.CSISRX.PLS.I.07.AR	Outpatient Prescription Drug Rider	56.5
RDR.CSISRXSBN.PLS.I.07.AR	Outpatient Prescription Drug Rider Schedule of Benefits	52.1
VISION.RDR.CSIS.I.AR	Vision Care Services Rider	60.4
DENTAL.RDR.CSIS.I.AR	Dental Services Rider	49.6

UnitedHealthcare
A UnitedHealth Group Company

March 6, 2009

UnitedHealthcare
5901 Lincoln Drive Edina MN 55436

Ms. Rosalind Minor
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: United HealthCare Insurance Company, NAIC Group# 0707, NAIC #79413

DISCRETIONARY GROUP HEALTH INSURANCE FORMS FILING - Formal Submission - Child Support Insurance Solution - Forms POL-CSIS.I.07.AR, et al. See enclosed Forms Listing

Dear Ms. Minor:

Thank you for all your cooperation and assistance with this project.

As we discussed over the telephone earlier this week, we have finally received approval from the Office of Child Support Enforcement of our Child Support Insurance Solution forms. As a result, we are submitting the forms referenced on the enclosed list with your Department for formal review and approval.

To clarify, these forms and our Child Support Insurance Solution product/program were discussed during many meetings with you and Dan Honey of your Department during last year. You also performed a "preliminary review" of the forms in August and September of last year, to help us identify potential problem areas. Some additional changes were made to these forms after we made the changes you requested during your "preliminary review". We can provide you with some redline comparison documents that will help you identify the changes and reduce the review time required, if you would like. Please let me know.

These enclosed forms are new and do not replace any forms currently filed with your Department. The forms support our group health Child Support Insurance Solution product, which will provide medical coverage for children in Arkansas who are subjects of Medical Child Support Orders managed by the State in accordance with Title IV-D of the Social Security Act. As we previously discussed, we are assuming this program of group health insurance will need to be filed on a "discretionary group" basis, due to its unique purpose and structure.

The benefits and coverages provided in the CSIS program will not include all of the Arkansas mandated benefits and will be filed in accordance with Arkansas Statutes 23-79-801 et seq. In addition, since the enclosed forms have been developed to reflect Arkansas-specific laws and regulations, they will not be filed or used in our domiciliary state of Connecticut.

Forms for Which We Seek Approval

The forms for which we seek approval are identified on the attached “Forms Listing.” The readability/Flesch score is provided, as well.

These materials represent final printed format (with the exception of variable text and corresponding instructions—please see the following paragraphs for explanation).

Explanation of Insert Forms and Variable Text

The forms contained in this filing are to be used on an insert form basis.

Each insert form is made up of:

- **Nonvariable Text** that always appears in an issued document.
- **Variable Text** that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets]. Whenever text is bracketed, we have included text that explains the logic of the variable; brackets do not appear in the document issued to a member.
- **Instructional text** provides the logic for when text is included or removed. Please note that instructional text appears only in the filing copy and will not appear in the document issued to a member. Following are two examples of instructional text:

Include when group purchases benefits for ostomy supplies.

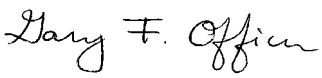
Include when notification is required for hospice care.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the Enrolling Group and Subscribers regarding access and alternatives to electronic issuance.

If you have any questions or concerns regarding these forms or the submission, please contact me using the information below.

Thank you very much for your continued assistance and cooperation.

Sincerely,



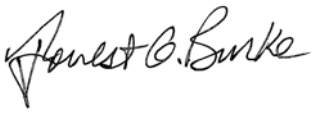
Gary F. Officer
Sr. Contract Specialist
United HealthCare Insurance Company
Ph: (952) 992-5515, Fax: (952) 992-5105
Email: gary_f_officer@uhc.com
Cellphone: 651-308-3225.

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: United HealthCare Insurance Company

Form Number(s): POL-CSIS.I.07.AR, et al. (see attached Forms Listing which contains the Flesch Score for each submittted form.

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Forrest G. Burke
Name

Secretary
Title

March 6, 2009
Date

Forms Listing

Child Support Insurance Solution

United HealthCare Insurance Company

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Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Section 2 Exclusions	03/10/2009	COC-CSISCP.EXC.I.07.AR 3-10-09.pdf
No original date	Form	Amendment to Group Policy	03/06/2009	
No original date	Form	Intro to Your Certificate	03/06/2009	COC-CSISCP.INT.I.07.AR.pdf
No original date	Form	Your Responsibilities	03/06/2009	COC-CSISCP.YRP.I.07.AR.pdf
No original date	Form	Table of Contents	03/06/2009	COC-CSISCP.TOC.I.07.AR.pdf
No original date	Form	Section1 Covered Health Services	03/06/2009	COC-CSISCP.CHS.I.07.AR.pdf
No original date	Form	Section 2 Exclusions	03/06/2009	COC-CSISCP.EXC.I.07.AR.pdf
No original date	Form	Section 3 Coverage Begins	03/06/2009	COC-

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

CSISCP.BGN.I.07.AR.pdf

SERFF Tracking Number:	*UHLC-126065089*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41742*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002B Large Group Only - POS*
Product Name:	*Child Support Insurance Solution - Group Health*		
Project Name/Number:	*AR CSIS/CSIS - AR 3-2009*		

No original date	Form	Section 4 Coverage Ends	03/10/2009	COC-CSISCP.END.I.07.AR 3-10-09.pdf
No original date	Form	Section 4 Coverage Ends	03/06/2009	COC-CSISCP.END.I.07.AR.pdf
No original date	Form	Section 8 General Legal Provisions	03/06/2009	COC-CSISCP.LGL.I.07.AR.pdf
No original date	Form	Section 9 Defined Terms	03/06/2009	COC-CSISCP.DEF.I.07.AR.pdf

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.

[2]Include when group purchases benefits for chiropractic treatment.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [[2]Chiropractic Treatment and] osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

[1]Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits.

[2]Include when group purchases accidental dental benefits. [3] Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits. [4]Include when group purchases dental anesthesia and hospitalization benefits. and hospitalization benefits.

[[1]This exclusion does not apply to [[2]accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only*] [[3]or] [[4]dental services for which Benefits are provided as described under *Dental Services - Anesthesia and Hospitalization*, in *Section 1: Covered Health Services*.]

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

[1]Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits.

[2]Include when group purchases accidental dental benefits. [3] Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits. [4]Include when group purchases dental anesthesia and hospitalization benefits. and hospitalization benefits.

[[1]This exclusion does not apply to [[2]accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only*] [[3]or] [[4]dental services for which Benefits are provided as described under *Dental Services - Anesthesia and Hospitalization*, in *Section 1: Covered Health Services*.]

[1]Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits.

[2]Include when group purchases accidental dental benefits. [3] Include when group purchases accidental dental benefits and/or dental anesthesia and hospitalization benefits. [4]Include when group purchases dental anesthesia and hospitalization benefits. and hospitalization benefits.

3. Dental implants, bone grafts, and other implant-related procedures. [[1]This exclusion does not apply to [[2]accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only*] [[3]or] [[4]dental services for which Benefits are provided as described under *Dental Services - Anesthesia and Hospitalization*, in *Section 1: Covered Health Services*.]
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Home coagulation testing equipment.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
   - Ventricular assist devices.
4. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
5. Oral appliances for snoring.

Include when the group purchases benefits for prosthetics and delete variable exclusion #6 further below.

[6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.]

Include when the group purchases benefits for prosthetics.

[7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.]

Include when group does not purchase benefits for prosthetics and delete the variable exclusions #6 and 7 above.

[6.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

1. Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

Include when the group purchases benefits for clinical trials.

[This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.]

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Subscribers with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Subscribers who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

[1]Include when group does not purchase benefits for durable medical equipment.

G. Medical Supplies [[1]and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

Include when group does not purchase benefits for ostomy supplies.

   - [Ostomy supplies.]

This exclusion does not apply to:

Include only when group purchases benefits for durable medical equipment.

   - [Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.]
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

Include only when group purchases benefits for ostomy supplies.

   - [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

[1]Include only when group purchases benefits for durable medical equipment.

2. Tubings and masks [[1]except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

Include when group does not purchase benefits for durable medical equipment.

[3. Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health/Substance Abuse

When group purchases MH/SA coverage, keep exclusions 1-8 and delete exclusion #9. When group does not purchase MH/SA coverage, keep exclusions 6 (except for the text variable) and 9, delete all remaining exclusions (1 - 5, 7 and 8).

[1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* manual or in the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association*.]

[1]Include if group purchases MH benefits.

[2]Include if group purchases SA benefits.

[3]Include if group purchases MH and SA benefits.

[2. [[1]Mental Health Services] [[3]and] [[2]Substance Abuse Services] that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.]

[3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.]

[4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.]

[5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]

[4]Delete when group does not purchase MH/SA benefits.

[6.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements [[4], unless authorized by the Mental Health/Substance Abuse Designee].

[5]Include the following if conversion from inpatient to residential treatment is not selected.

[[5]7. Residential treatment services.]

[8. Services or supplies for the diagnosis or treatment of [[1]Mental Illness][[2], alcoholism or substance abuse] disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:

- Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Include when plan does not include MH/SA benefits.

[6]Include when the group provides MH/SA benefits under a separate plan.

[9. Services for the treatment of [[1]mental illness or mental health conditions] [[3]and] [[2]substance abuse services and chemical dependency services] [[6]that the Enrolling Group has elected to provide through a separate benefit plan].]

I. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

[1]Include when group purchases plan with coverage for Medical Foods. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

2 Enteral feedings, even if the sole source of nutrition. [[1]This exclusion does not apply to Medical Foods for which Benefits are provided as described in *Section 1: Covered Health Services*.]

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

J. Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters, dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
   - Electric scooters.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.

- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Speech generating devices.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

7. Wigs regardless of the reason for the hair loss.

Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion. (Also modify Section 9 by deleting definitions of Continuous Creditable Coverage and Preexisting Condition.)

[L. Preexisting Conditions]

[1]This paragraph will be included when group chooses to apply a 12 months preexisting condition exclusion to all Subscribers.

[1. [1]Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months.

This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

[M.] Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.

2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Include when group does not purchase rehabilitation services benefits, except when only speech therapy or when only speech therapy and chiropractic treatment are purchased. [1]Speech Therapy is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[4. Outpatient rehabilitation services. Examples include physical therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, chiropractic treatment, post-cochlear implant aural therapy and vision therapy. [[1]This exclusion does not apply to speech therapy for which Benefits are provided as described in *Section 1: Covered Health Services*.]

[5.] Psychosurgery.

[6.] Sex transformation operations.

[7.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

[8.] Biofeedback.

Include when group purchases rehabilitation services benefits that do not include chiropractic treatment.

[9. Chiropractic treatment (the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

[10.] The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.

[1]Include if group purchases mandated benefit for TMJ and/or optional benefit for Musculoskeletal Disorders.

[2]Include if group purchases TMJ Services. This is a mandated benefit in Arkansas, but it can be excluded in accordance with AR statute 23-79-801, et seq.

[3]Include if group purchases both TMJ services and Musculoskeletal Disorders.

[4]Include if group purchases Musculoskeletal Disorders.This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. This benefit can also be excluded in accordance with AR statute 23-79-801, et seq.

[11.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. [[1]This exclusion does not apply to [[2]*Temporomandibular Joint Services* for which Benefits are provided as described in *Section 1: Covered Health Services under Additional Benefits Required By Arkansas Law* [[3]or to][[4]services for treatment of *Musculoskeletal Disorders of the Face, Neck or Head* for which Benefits are provided as described in *Section 1: Covered Health Services* under *Additional Benefits Required By Arkansas Law*]].

[12.] Surgical and non-surgical treatment of obesity.

[13.] Stand-alone multi-disciplinary smoking cessation programs.

[N.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.
4. Foreign language and sign language interpreters.

[1]Remove all bracketed text to provide benefits for voluntary sterilization, pregnancy termination, and contraceptive supplies and other services. For groups that choose to modify, remove brackets as applicable to describe which of these services the group has chosen to exclude.

[O.] Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

[4.] The reversal of voluntary sterilization [[1]and voluntary sterilization].

[[5.] [1]Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[[6.] [1]Contraceptive supplies and services.]

[[7.] [1]Fetal reduction surgery.]

Include the following if group is not purchasing full Maternity Services but is purchasing Complications of Pregnancy only.

[[8.] Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

[P.] Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [[1]Mental Illness] [[2]mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

[Q.] Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

Include exclusion #4 when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.

[4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

[R.] Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

[S.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care.
3. Domiciliary care.
4. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:
   - No skilled services are identified.
   - Skilled nursing resources are available in the facility.

- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

[T.] Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.

Include when group does not purchase benefits for vision exams.

[2. Routine vision examinations, including refractive examinations to determine the need for vision correction.]

[3.] Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

[4.] Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

[5.] Eye exercise therapy.

[6.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

[U.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
8. Autopsy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to [United HealthCare Insurance Company].

When we use the words "you" and "your," to describe the rights to Benefits under the Policy, we are referring to people who are Subscribers, as that term is defined in *Section 9: Defined Terms*. When we use the words "you" and "your" to describe responsibilities under the Policy, we are also referring to the parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

If we fail to provide you with reasonable and adequate service, you should feel free to contact the Arkansas Insurance Department at:

Arkansas Insurance Department

[Consumer Services Division]

[1200 West Third Street]

[Little Rock, AR 72201-1904]

[(800) 852-5494] or [(501) 371-2640]

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber as that term is defined in *Section 9: Defined Terms*.
- We must receive the required Premiums.

Your Enrolling Group may require you to make certain payments to them or us, in order for you to be enrolled under the Policy and receive Benefits. You are responsible for making these payments and we are entitled to reimbursement of attorney's fees and any other costs related to collecting delinquent payments. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Certificate of Coverage Table of Contents

Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Subscriber and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).

[1]*Include when an Annual Maximum Benefit applies.*

- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services[[1], any Annual Maximum Benefit,] and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Include when group purchases benefits for clinical trials.

[[2.] Clinical Trials]

[Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.

Include to support expanding clinical trial benefit to other diseases or disorders.

- [Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.]

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Subscriber is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - *Department of Defense (DOD)*.
  - *Veterans Administration (VA)*.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.]

Include when group purchases CHD benefit.

[[3.] Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.]

Include when group purchases accidental dental benefit.

[[4.] Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[5.] Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Subscribers with diabetes.

Diabetic Self-Management Items

Include paragraph below when group purchases the drug rider.

[1]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Subscriber. [[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

Include paragraph and bulleted list below when group does not purchase the drug rider.

[1]Include only when group does not purchase benefits for durable medical equipment.

[2]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps [[1]that are not fully implanted into the body,] and supplies for the management and treatment of diabetes, based upon the medical needs of the Subscriber including, but not limited to:

- [[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

Include when group purchases durable medical equipment benefit.

[6.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).

- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

Include when DME Benefit is tiered and tiers are not to be included in COC.

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card.]

Include when DME Benefit is tiered and tiers are to be included in COC.

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps.
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[7.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Include if plan design includes retrospective review of emergency services.

[Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.]

[8.] Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

[9.] Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the Subscriber is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

[10.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

[1]*Include if RAPLs and consulting physicians are paid under the facility charge.*

- [[1]Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

- [[2]Emergency room Physicians. (Benefits for all other Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.)]

[11.] Lab, X-Ray and Diagnostics - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office] include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

[12.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[1]Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

Include when group purchases plan with inpatient/intermediate MH/SA benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. Remove entire benefit if group purchases MH full parity.

[1]Include if group purchases SA benefits.

[[13.] Mental Health [[1]and Substance Abuse]Services - Inpatient and Intermediate]

[Mental Health [[1]and Substance Abuse]Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

[2]Include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care.

The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[2]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as partial hospitalization or intensive outpatient programs) or Transitional Care at the discretion of the Mental Health/Substance Abuse Designee.

One Inpatient day is equivalent to:

[3]Include first bullet only if customer purchases inpatient conversion to residential treatment.

- [[3]One day of residential treatment.]
- Two sessions of partial hospitalization/day treatment.
- Five sessions of intensive outpatient treatment.
- Six outpatient visits.
- Ten days of Transitional Care (either sober living or transitional living arrangements).]

Mental Health [[1]and Substance Abuse]Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health [[1]or Substance Abuse]Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Mental Health [[1]and Substance Abuse]Services.]

Include when group purchases plan with outpatient MH/SA benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. Remove entire benefit if group purchases MH full parity.

[1]Include if group purchases SA benefits.

[[14.] Mental Health [[1]and Substance Abuse]Services - Outpatient]

[Mental Health [[1]and Substance Abuse]Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health[[1], substance abuse and chemical dependency] evaluations and assessment.
- Diagnosis.

- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Referrals to a Mental Health[[1]or Substance Abuse] Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health [[1]and Substance Abuse] Services.]

Include when group purchases benefits for ostomy supplies.

[[15.] Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.]

[16.] Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Subscriber's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Include only when benefits are tiered for Pharmaceutical Products.

[Pharmaceutical Products are assigned to various tiers. The *PDL Management Committee* makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether notification requirements should apply. Economic factors may include, but are not limited to, the Pharmaceutical Product's acquisition cost including, but not limited to, available rebates, and assessments on the cost effectiveness of the Pharmaceutical Product.]

[17.] Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

[18.] Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services for Preventive Care provided in a Physician's office are described under *Preventive Care Services*.

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.

[[1]Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.]

[2]Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.

[[2]When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[1]Include when full Maternity Services benefits are sold.

[2]If Maternity Services are excluded, Complications of Pregnancy must always be included.

[19.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]

[1]Include #1 below when Benefits are available for full Maternity Services and delete option #2 further below.

[[1]Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.]

[2]Include #2 below when Benefits are available only for Complications of Pregnancy and delete option #1 above.

[[2]Benefits for Complications of Pregnancy include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

Both before and during a Pregnancy, Benefits are provided for the services of a genetic counselor when provided or referred by a Physician. Covered Health Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

[20.] Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

Physician office services:

- Routine physical examinations.
- Well baby and well child care.
- Immunizations.
- Hearing screening.

Lab, X-ray or other preventive tests:

- Screening mammography.
- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening.
- Prostate cancer screening.
- Bone mineral density tests.

Include when group purchases benefits for prosthetic devices.

[21.] [Prosthetic Devices]

[External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.]

[22.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Subscriber may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Coverage is provided for at least a minimum of 48 hours for the Hospital - Inpatient Stay related to the mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[1]Include when only speech therapy is purchased or when only speech therapy and chiropractic treatment are purchased. Speech therapy is mandated.

[2]Include when group purchases benefits for chiropractic treatment.

[3]Include when group purchases benefits for rehabilitation services benefits in addition to mandated speech therapy.

[23.] Rehabilitation Services - Outpatient [[1]Speech]Therapy [[2]and Chiropractic Treatment]

Short-term outpatient rehabilitation services, limited to:

- [[3]Physical therapy.
- Occupational therapy.]

[2]Include when group purchases benefits for chiropractic treatment.

- [[2]Chiropractic Treatment.]
- Speech therapy for loss or impairment of speech.
- [[3]Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

[24.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[1]Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

[25.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

- [[1]Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

- [[2]Benefits for Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.]

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Subscribers who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

[26.] Surgery - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical* Services.]

[4]Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[27.] Therapeutic Treatments - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office], including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

[2]*Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.*

[[2]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[28.] Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

[29.] Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Include when group purchases benefits for vision exams.

[[30.] Vision Examinations]

[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

Additional Benefits Required By Arkansas Law

[31.] Dental Services - Anesthesia and Hospitalization

Covered Health Services for anesthesia and related hospital services in conjunction with a dental procedure, if the anesthesia and related hospital services are deemed medically necessary by the patient's Physician or dentist and the following conditions are met:

- The patient is a child age seven or younger who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or Alternate Facility.

- The patient is diagnosed with a serious mental or physical condition or a significant behavioral problem as determined by the patient's Physician.

[32.] Medical Foods

Coverage for Medical Foods and Low Protein Modified Food Products which are for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism and administered under the direction of a Physician is provided if the cost of the Medical Foods and Low Protein Modified Food Products for an individual or a family with a dependent person or persons exceeds the $2,400 per year, per person income tax credit. If the cost of these products does not exceed the per person income tax credit, coverage is not provided.

Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing.

[[33.] Mental Health Services - Inpatient and Intermediate]

[Mental Health Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Mental Health Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Mental Health Services.]

Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing.

[[34.] Mental Health Services - Outpatient]

[Mental Health Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health Services.]

This is a mandated offer in Arkansas. If group chooses not to have this benefit, they must refuse this benefit in writing.

[[35.] Musculoskeletal Disorders of the Face, Neck or Head]

[Diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, whether they are the

result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment will also include both surgical and non-surgical procedures. Coverage will be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.]

Include ONLY when group purchases plan with inpatient/intermediate SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing.

[[36.] Substance Abuse Services - Inpatient and Intermediate]

[Substance Abuse Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

[1]Include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care.

The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as partial hospitalization or intensive outpatient programs) or Transitional Care at the discretion of the Mental Health/Substance Abuse Designee.

One Inpatient day is equivalent to:

[2]Include first bullet only if customer purchases inpatient conversion to residential treatment.

- [[2]One day of residential treatment.]
- Two sessions of partial hospitalization/day treatment.
- Five sessions of intensive outpatient treatment.
- Six outpatient visits.
- Ten days of Transitional Care (either sober living or transitional living arrangements).]

Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Substance Abuse Services.]

Include ONLY when group purchases plan with outpatient SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing.

[[37.] Substance Abuse Services - Outpatient]

[Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Substance abuse and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).

- Crisis intervention.

Referrals to a Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Substance Abuse Services.]

[38.] Temporomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies, and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations, and TMJ implants.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.

[2]*Include when group purchases benefits for chiropractic treatment.*

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [[2]Chiropractic Treatment and] osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

[1]*Include when group purchases accidental dental benefit.*

This exclusion does not apply to [[1]accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* or] dental services for which Benefits are

provided as described under *Dental Services - Anesthesia and Hospitalization,* in *Section 1: Covered Health Services*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

[1]*Include when group purchases accidental dental benefit.*

This exclusion does not apply to [[1]accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* or] dental services for which Benefits are provided as described under *Dental Services - Anesthesia and Hospitalization,* in *Section 1: Covered Health Services*.

[1]*Include when group purchases accidental dental benefit.*

3. Dental implants, bone grafts, and other implant-related procedures. This exclusion does not apply to [[1]accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* or] dental services for which Benefits are provided as described under *Dental Services - Anesthesia and Hospitalization,* in *Section 1: Covered Health Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Home coagulation testing equipment.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

- Ventricular assist devices.

4. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.

5. Oral appliances for snoring.

Include when the group purchases benefits for prosthetics and delete variable exclusion #6 further below.

[6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.]

Include when the group purchases benefits for prosthetics.

[7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.]

Include when group does not purchase benefits for prosthetics and delete the variable exclusions #6 and 7 above.

[6.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

1. Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

Include when the group purchases benefits for clinical trials.

[This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.]

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Subscribers with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Subscribers who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

[1]Include when group does not purchase benefits for durable medical equipment.

G. Medical Supplies [[1]and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

Include when group does not purchase benefits for ostomy supplies.

   - [Ostomy supplies.]

This exclusion does not apply to:

Include only when group purchases benefits for durable medical equipment.

   - [Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.]
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

Include only when group purchases benefits for ostomy supplies.

   - [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

[1]Include only when group purchases benefits for durable medical equipment.

2. Tubings and masks [[1]except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

Include when group does not purchase benefits for durable medical equipment.

[3. Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health/Substance Abuse

When group purchases MH/SA coverage, keep exclusions 1-8 and delete exclusion #9. When group does not purchase MH/SA coverage, keep exclusions 6 (except for the text variable) and 9, delete all remaining exclusions (1 - 5, 7 and 8).

[1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* manual or in the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association*.]

[1]Include if group purchases MH benefits.

[2]Include if group purchases SA benefits.

[3]Include if group purchases MH and SA benefits.

[2. [[1]Mental Health Services] [[3]and] [[2]Substance Abuse Services] that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.]

[3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.]

[4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.]

[5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]

[4]Delete when group does not purchase MH/SA benefits.

[6.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements [[4], unless authorized by the Mental Health/Substance Abuse Designee].

[5]Include the following if conversion from inpatient to residential treatment is not selected.

[[5]7. Residential treatment services.]

[8. Services or supplies for the diagnosis or treatment of [[1]Mental Illness][[2], alcoholism or substance abuse] disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:

- Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Include when plan does not include MH/SA benefits.

[6]Include when the group provides MH/SA benefits under a separate plan.

[9. Services for the treatment of [[1]mental illness or mental health conditions] [[3]and] [[2]substance abuse services and chemical dependency services] [[6]that the Enrolling Group has elected to provide through a separate benefit plan].]

I. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.

- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to *Medical Foods* for which Benefits are provided as described in *Section 1: Covered Health Services*.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters, dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
   - Electric scooters.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Safety equipment.

- Speech generating devices.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
7. Wigs regardless of the reason for the hair loss.

Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion. (Also modify Section 9 by deleting definitions of Continuous Creditable Coverage and Preexisting Condition.)

[L. Preexisting Conditions]

[1]This paragraph will be included when group chooses to apply a 12 months preexisting condition exclusion to all Subscribers.

[1. [1]Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months.

This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

[M.] Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Include when group does not purchase rehabilitation services benefits, except for mandated speech therapy.

[4. Outpatient rehabilitation services. Examples include physical therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, chiropractic treatment, post-cochlear implant aural therapy and vision therapy. This exclusion does not apply to *speech therapy* for which Benefits are provided as described in *Section 1: Covered Health Services*.]

[5.] Psychosurgery.

[6.] Sex transformation operations.

[7.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

[8.] Biofeedback.

Include when group purchases rehabilitation services benefits that do not include chiropractic treatment.

[9. Chiropractic treatment (the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

[10.] The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.

[1]*Include if group purchases optional benefit for Musculoskeletal Disorders.*

[11.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. This exclusion does not apply to Temporomandibular Joint Services for which Benefits are provided as described in *Section 1: Covered Health Services* under *Additional Benefits Required By Arkansas Law* [[1] or to services for treatment of *Musculoskeletal Disorders of the Face, Neck or Head* for which Benefits are provided as described in *Section 1: Covered Health Services* under *Additional Benefits Required By Arkansas Law*].

[12.] Surgical and non-surgical treatment of obesity.

[13.] Stand-alone multi-disciplinary smoking cessation programs.

[N.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

- Has not been actively involved in your medical care prior to ordering the service, or
- Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

4. Foreign language and sign language interpreters.

[1]Remove all bracketed text to provide benefits for voluntary sterilization, pregnancy termination, and contraceptive supplies and other services. For groups that choose to modify, remove brackets as applicable to describe which of these services the group has chosen to exclude.

[O.] Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

[4.] The reversal of voluntary sterilization [[1]and voluntary sterilization].

[[5.] [1]Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[[6.] [1]Contraceptive supplies and services.]

[[7.] [1]Fetal reduction surgery.]

Include the following if group is excluding coverage for maternity benefits.

[[8.] Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

[P.] Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [[1]Mental Illness] [[2]mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

[Q.] Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

Include exclusion #4 when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.

[4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

[R.] Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

[S.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care.
3. Domiciliary care.
4. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:
   - No skilled services are identified.
   - Skilled nursing resources are available in the facility.
   - The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

[T.] Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.

Include when group does not purchase benefits for vision exams.

[2. Routine vision examinations, including refractive examinations to determine the need for vision correction.]

[3.] Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

[4.] Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

[5.] Eye exercise therapy.

[6.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

[U.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

- Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption.
- Related to judicial or administrative proceedings or orders.
- Conducted for purposes of medical research.
- Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
8. Autopsy.

Section 3: When Coverage Begins and Premiums

How to Enroll

The parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Eligible Person must complete an enrollment form. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

We and the Enrolling Group determine who is eligible to enroll under the Policy. Please note that if you were a Subscriber under the Policy and your coverage ended because you failed to pay Premium, you will not be considered eligible to re-enroll under the Policy until both of the following are met:

- All Premium owed for prior coverage has been paid to us.
- Three months has passed since the last day of prior coverage.

Eligible Person

An Eligible Person is a child who is a resident of Arkansas for whom medical coverage is required under a Medical Child Support Order and who meets the eligibility rules that we and the Enrolling Group establish. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not be enrolled.

New Eligible Persons

Coverage for a new Eligible Person begins on the date agreed to by the Enrolling Group and us if we receive the completed enrollment form and any required Premium.

Include the following paragraph only when two months' Premium payment is required.

[For an Eligible Person who becomes eligible after the effective date of the Policy, his or her effective date of coverage is the first day of the month following the date on which we have received at least 200% of monthly Premiums on the Eligible Person's behalf.]

Premiums

[1] *Include when either the Standard or one month Premium advance payment option applies. Delete when two months' Premium payment is required.*

All Premiums are payable in advance on a monthly basis. [[1]The first Premium is due and payable prior to the effective date of coverage. Subsequent] Premiums are due and payable no later than the first day of the month thereafter that the Policy is in effect.

A full month's Premium will be charged for any Subscriber who is covered under this Policy. Coverage is effective on the first of the month and ends at the end of the month. Premiums will not be prorated based upon the Subscriber's effective date or termination date of coverage. The only exception to this requirement is that a pro rata Premium, based on the number of days a Subscriber is actually covered under this Policy, will be charged for a Subscriber whose coverage is terminated due to death.

[1]Select the appropriate length of time for prior written notice, based on group requirement.

We reserve the right to change the *Schedule of Premium Rates* as described below. We will provide a [[1]31 - 120]-day prior written notice of any change in Premium.

Include when annual renewal structure applies.

[1]Insert month and date (but not the year) of the effective date of the group policy.

[When you first enroll for coverage under the Policy, the *Schedule of Premium Rates* that applies to your coverage will be in effect and will not change until the anniversary of the Enrolling Group's Policy. The anniversary of the Enrolling Group's Policy occurs each year on [[1]_____]. We reserve the right to change the Schedule of Premium Rates annually on the anniversary of the Enrolling Group's Policy.]

Include when quarterly renewal structure applies.

[When you first enroll for coverage under the Policy, the *Schedule of Premium Rates* that applies to your coverage will be in effect and will not change until the anniversary of the first day of your enrollment quarter under the Policy. We reserve the right to change the *Schedule of Premium Rates* annually on the anniversary of your enrollment quarter.

There are four enrollment quarters per calendar year: January 1 - March 31; April 1 - June 30; July 1 - September 30; and October 1 - December 31. The first day of these enrollment quarters are: January 1, April 1, July 1, and October 1.

For example, if your coverage is effective February 1, the *Schedule of Premium Rates* that applies to your coverage will be in effect and will not change until January 1 of the following year and January 1 each year thereafter that your coverage under the Policy is in effect.]

We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a material misrepresentation that resulted in the Premium rates being lower than they would have been if the material misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the material misrepresentation. For the purpose of this provision, a material misrepresentation is any oral or written communication or conduct, or combination of communication and conduct that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Include when grace period applies. Standard would be 31 days, but filed as variable to accommodate other state requirements or choice by group.

[Grace Period]

[A grace period of [31] days shall be granted for the payment of any Premium, during which time coverage under the Policy shall continue in force. If payment is not received within this [31] day grace period, coverage may be canceled after the [31st] day and the Subscriber shall be held liable for the cost of services received during the grace period.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **Failure to Pay Premium**

[1] Include when either the one or two month advance Premium options applies.

[2]Include when Standard payment option applies.

[3]Include only when two months' Premium payment option applies.

  Your coverage ends on the last day [[1]of the last calendar month for which Premium was paid in full] [[2]of the grace period, if the grace period expires and Premium remains unpaid]. [[3]Premium is considered to be paid in full when the initial two months Premium has been remitted and payment is received every month thereafter. If a monthly Premium payment is missed, coverage will terminate on the last day of the following calendar month. For example: Your coverage begins May 1 (by having paid two months Premium by April 30). If you don't submit the May Premium payment, your coverage will terminate on June 30.]

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber. Please refer to *Section 9: Defined Terms* for complete definitions of the terms Eligible Person and Subscriber.

- **We Receive Notice to End Coverage**

  Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to you that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or you knowingly gave us false material information. Examples include false information relating to eligibility.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

- The date your Inpatient Stay ends, or
- The date you have exhausted the Inpatient Stay benefits under the Policy.

Continuation of Coverage is mandated in Arkansas for a period of 120 days. The group may elect to extend the Continuation of Coverage.

[Continuation of Coverage]

All references to the limiting age below are variable to allow adjustment by the State.

[1]Include when the 120-day Continuation of Coverage option #1 is purchased and delete option #2.

[2]When the group does not purchase option #1, delete option #1 and include option #2.

[3]Enter the appropriate classification (State, Commonwealth, etc.)

[4]Enter the appropriate state name

[[1]Continuation of coverage is available for a Subscriber who has not yet reached the limiting age of [19], but who would otherwise cease to be eligible because he or she is no longer subject to a *Medical Child Support Order* managed by the [[3]State of [[4]Arkansas]] in accordance with Title IV-D of the Social Security Act.

- If this occurs, we will extend the coverage until the earlier of the following dates:
- 120 days after continuation of coverage began.
- The last day of the calendar month in which the Subscriber reaches the limiting age of [19].

Continuation of coverage is subject to continued timely payment of the required Premium and all other terms, conditions, limitations and exclusion of the Policy except those that are specifically modified in this provision.]

Include when group wants to provide continuation of coverage to children who are no longer subject to a Medical Child Support Order managed by the State (with no 120-day limitation) until they reach the limiting age.

[[2]Continuation of coverage is available for a Subscriber who has not yet reached the limiting age of [19], but who would otherwise cease to be eligible because he or she is no longer subject to a *Medical Child Support Order* managed by the [[3]State of [[4]Arkansas]] in accordance with Title IV-D of the Social Security Act.]

If this occurs, we will extend the coverage until the last day of the calendar month in which the Subscriber reaches the limiting age of [19].]

Continuation of coverage is subject to continued timely payment of the required Premium and all other terms, conditions, limitations and exclusion of the Policy except those that are specifically modified in this provision.]

Conversion is mandated and must be included in Arkansas.

[Conversion]

[If your coverage under the Policy terminates, you may be able to apply for conversion coverage without furnishing evidence of insurability. You will not be eligible for conversion if:

- The termination of coverage under the Policy results from your failure to make timely payment of the Premium.
- The entire Policy ends and is replaced by similar coverage within 31 days.
- You are eligible for Medicare coverage or full coverage under any other group accident and health policy or contract (coverage must provide benefits for all preexisting conditions to be considered full coverage).

Application and payment of the initial Premium must be made within 30 days after coverage ends under the Policy. The effective date of the converted policy is the day following the termination of the insurance under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **Failure to Pay Premium**

[1] Include when either the one or two month advance Premium options applies.

[2]Include when Standard payment option applies.

[3]Include only when two months' Premium payment option applies.

  Your coverage ends on the last day [[1]of the last calendar month for which Premium was paid in full] [[2]of the grace period, if the grace period expires and Premium remains unpaid]. [[3]Premium is considered to be paid in full when the initial two months Premium has been remitted and payment is received every month thereafter. If a monthly Premium payment is missed, coverage will terminate on the last day of the following calendar month. For example: Your coverage begins May 1 (by having paid two months Premium by April 30). If you don't submit the May Premium payment, your coverage will terminate on June 30.]

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber. Please refer to *Section 9: Defined Terms* for complete definitions of the terms Eligible Person and Subscriber.

- **We Receive Notice to End Coverage**

  Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to you that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**

Fraud or misrepresentation, or you knowingly gave us false material information. Examples include false information relating to eligibility.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

- The date your Inpatient Stay ends, or
- The date you have exhausted the Inpatient Stay benefits under the Policy.

Include when Enrolling Group purchases extended coverage.

[Additional Extended Coverage]

All references to the limiting age below are variable to allow adjustment by the State.

Include when group wants to extend coverage to children who move outside the State.

[Extended coverage is available for a Subscriber who has not yet reached the limiting age of [19], but who would otherwise cease to be eligible because he or she is no longer a resident of the State of Arkansas. If this occurs, we will extend the coverage until the earlier of the following dates:

- The last day of the calendar month in which the Subscriber reaches the limiting age of [19].
- The last day of the calendar month in which the Subscriber is no longer subject to a *Medical Child Support Order* managed by the State in accordance with Title IV-D of the Social Security Act.

Extended coverage is subject to continued timely payment of the required Premium and all other terms, conditions, limitations and exclusion of the Policy except those that are specifically modified in this provision.]

Include when group wants to extend coverage to children who are no longer subject to a Medical Child Support Order managed by the State until they reach the limiting age.

[Extended coverage is available for a Subscriber who has not yet reached the limiting age of [19], but who would otherwise cease to be eligible because he or she is no longer subject to a *Medical Child Support Order* managed by the State in accordance with Title IV-D of the Social Security Act. If this occurs, we will extend the coverage until the earlier of the following dates:

- The last day of the calendar month in which the Subscriber reaches the limiting age of [19].
- The last day of the calendar month in which the Subscriber ceases to be a resident of the State of Arkansas.

Extended coverage is subject to continued timely payment of the required Premium and all other terms, conditions, limitations and exclusion of the Policy except those that are specifically modified in this provision.]

Include when group wants to extend coverage to both children who move outside the State and to those who are no longer subject to the court order.

[Extended coverage is available for a Subscriber who has not yet reached the limiting age of [19], but who would otherwise cease to be eligible because he or she is no longer a resident of the State of Arkansas or is no longer subject to a *Medical Child Support Order* managed by the State in accordance with Title IV-D of the Social Security Act. If this occurs, we will extend the coverage until the last day of the calendar month in which the Subscriber reaches the limiting age of [19].

Extended coverage is subject to continued timely payment of the required Premium and all other terms, conditions, limitations and exclusion of the Policy except those that are specifically modified in this provision.]

[Continuation of Coverage [and Conversion]]

[If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with state law.]

[Qualifying Events for Continuation Coverage under State Law]

[Coverage must have ended due to loss of eligibility as a Subscriber.

[Notification Requirements and Election Period for Continuation Coverage under State Law]

[The Enrolling Group will provide you with written notification of the right to continuation coverage within [__] days of when coverage ends under the Policy. You must elect continuation coverage within [__] days of receiving this notification. You should obtain an election form from the Enrolling Group and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.]

[Terminating Events for Continuation Coverage under State Law]

[Continuation coverage under the Policy will end on the earliest of the following dates:

- [[XX] months] [[XX] days] from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.]

[Conversion]

[If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- You cease to be eligible as a Subscriber.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.]

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Premiums to us.
- Notifying you of the termination of the Policy.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.

- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Subscriber who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Subscriber's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

[1]Include when rebates are passed on to Subscribers. [2]Include when rebates are not passed on to Subscribers.

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We [[1]do] [[2]do not] pass these rebates on to you, [[1]and they are applied to any Annual Deductible and] [[2]nor are they applied to any Annual Deductible or] taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our

related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Subscribers

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.

- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Subscriber, that Subscriber, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Subscriber or did not legally have to be paid by the Subscriber.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Subscriber agrees to help us get the refund when requested.

If the Subscriber, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Subscriber that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

[1]Include when group purchases MH coverage.

[2]Include when group purchases SA coverage.

[3]Include when group purchases MH and SA coverage.

[[1-3]An Alternate Facility may also provide [[1]Mental Health Services] [[3]or] [[2]Substance Abuse Services] on an outpatient or inpatient basis.]

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Include only when an Annual Maximum Benefit applies.

[Annual Maximum Benefit - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits*, and any attached Riders and/or Amendments.

Include when group purchase benefits for chiropractic treatment.

[**Chiropractic Treatment** -the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Include when the group purchases benefits for complications of pregnancy.

[Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period.]

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Include definition for groups that purchase Preexisting Condition exclusion.

[**Continuous Creditable Coverage** - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.

- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, [[1]Mental Illness,][[2]mental illness,] substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Subscriber, Physician, facility or any other person.
- Described in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.

- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Subscribers on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on [UnitedHealthcareOnline].

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a child who is a resident of the State of Arkansas and who meets each of the following conditions:

Limiting age is variable to allow adjustment by the State.

- At least seven months old but less than [19] years old.
- Subject of a *Medical Child Support Order* managed by the State of Arkansas in accordance with *Title IV-D* of the *Social Security Act*.

An Eligible Person does not include a child who was previously enrolled under the Policy whose coverage ended for failure to pay Premium. Such child will not be considered eligible to re-enroll under the Policy until both of the following are met:

- All Premium owed for prior coverage has been paid to us.
- Three months has passed since the last day of prior coverage.

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [[1]Mental Illness][[2]mental illness] which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolling Group - the defined or legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

Include when the group purchases benefits for clinical trials.

- [Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.]
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an

effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Include when group purchases inpatient/intermediate MH/SA benefits.

[Intermediate Care - Mental Health/Substance Abuse treatment that encompasses the following:

[1]Include the first bullet only if the customer purchases the option to convert inpatient MH/SA days to residential treatment.

- [[1]Care at a residential treatment center which provides a program of effective Mental Health/Substance Abuse treatment and meets all of the following requirements:
  - It is established and operated in accordance with any applicable state law.
  - It provides a program of treatment approved by a Physician and the Mental Health/Substance Abuse Designee.
  - It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
  - It provides at least the following basic services:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.]
- Care at a partial hospital/day treatment program, which is a freestanding or Hospital-based program that provides services for at least 20 hours per week.
- Care through an intensive outpatient program, which is a freestanding or Hospital-based program that provides services for at least nine hours per week. This encompasses half-day (i.e. less than four hours per day) partial Hospital programs.]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week; or

- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Low Protein Modified Food Product - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician.

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

Medical Food - a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Include when group purchases MH/SA benefits.

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *International Classification of Diseases* manual or in the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

Include when group purchases MH/SA benefits.

[Mental Health/Substance Abuse Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Policy.]

Include when group purchases MH/SA benefits.

[Mental Illness - those mental illnesses and disorders listed in the *International Classification of Diseases* manual and the *current Diagnostic and Statistical Manual of Mental Disorders* of the *American Psychiatric Association*, unless specifically excluded under the Policy.]

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [[1]by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Include only when a per occurrence deductible applies.

[Per Occurrence Deductible - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, audiologist, certified registered nurse anesthetist, dental technician, licensed professional counselor, osteopath, psychological examiner, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Include definition if group has purchased a preexisting condition exclusion. [1]Select the appropriate "look back period."

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [[1]three] [[1]six] month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include

Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber, in accordance with the terms of the Policy.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

[[1][Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Saving Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.]

[1]Include when group purchases MH/SA benefits. [2]Include when group does not purchase MH/SA benefits.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [[1]Mental Illness][[2]mental illness] or substance abuse, regardless of the cause or origin of the [[1]Mental Illness][[2]mental illness] or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person on whose behalf the Policy is issued to the Enrolling Group. References to "you" and "your" throughout this *Certificate* to describe Benefits are references to a Subscriber. References to "you" and "your" to describe responsibilities under the Policy, are also references to the parent(s) or guardian(s) as dictated by a court order who are authorized to act on behalf of the Subscriber.

Include when group purchases MH/SA benefits.

[Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

Include when group purchases inpatient/intermediate MH/SA benefits.

[Transitional Care - Mental Health/Substance Abuse Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Subscriber with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Subscriber with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com].

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Subscriber with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Subscriber must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.

- At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.